Brief Pain Inventory (Short Form)

Study ID# _____ Hospital# 10-14-80

Do not write above this line

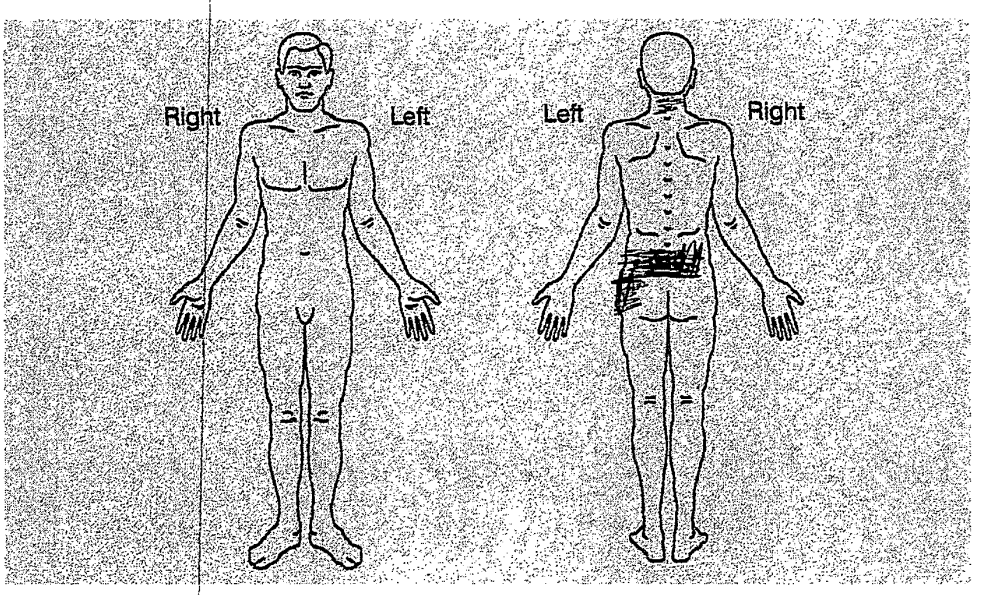
Date: 07-18-16 Time: 10:30

Name: Smith (Last) Michelle (First) _____ (Middle Initial)

1) Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?

1. Yes 2. No

2) On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.



3) Please rate your pain by circling the one number that best describes your pain at its WORST in the past 24 hours.

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as you can imagine

4) Please rate your pain by circling the one number that best describes your pain at its LEAST in the past 24 hours.

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as you can imagine

5) Please rate your pain by circling the one number that best describes your pain on the AVERAGE.

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as you can imagine

6) Please rate your pain by circling the one number that tells how much pain you have RIGHT NOW.

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as you can imagine

7) What treatments or medications are you receiving for your pain?

1 tab q 4-5 hrs; 400mg QiD; 4mg 1 - 1½ q 4-5; 20mg #45 PRN 30 days

Nortriptyline, Neurotin, Zanaflex, Oxymorphone, Oxycodone

8) In the past 24 hours, how much relief have pain treatments or medications provided? Please circle the one percentage that most shows how much RELIEF you have received.

30mg BiD

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
No relief										Complete relief

9) Circle the one number that describes how, during the past 24 hours, pain has interfered with your:

A. General activity:

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

B. Mood:

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

C. Walking ability:

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

D. Normal work (includes both work outside the home and housework):

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

E. Relations with other people:

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

F. Sleep:

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

G. Enjoyment of life:

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

Review of Systems

Mark the following symptoms that you currently suffer from: Improved.

Constitutional:	☐ Chills	☑ Difficulty sleeping	☐ Easy bruising
	☐ Night Sweats	☐ Fatigue	☐ Fevers
	☐ Insomnia	☐ Low sex drive	☐ Tremors
	☐ Unexplained Weight Gain		☐ Weakness
	☐ Unexplained Weight Loss		
Eyes:	☐ Recent Visual changes		
Ears/Nose/Throat/Neck:	☐ Dental Problems	☐ Earaches	☐ Hearing Problems
	☐ Nosebleeds	☐ Sinus problems	
Cardiovascular:	☐ Chest Pain	☐ Bleeding Disorder	☐ Blood Clots
	☐ Fainting	☐ Palpitations	☐ Swelling in feet
	☐ Shortness of breath during sleep		
Respiratory:	☐ Cough	☐ Wheezing	☐ Shortness of breath
Gastrointestinal:	☐ Constipation	☐ Acid Reflux	☐ Abdominal Cramps
	☐ Diarrhea	☐ Nausea/Vomiting	☐ Hernia
Musculoskeletal: well-controlld pain this months	☑ Back Pain	☑ Joint Pains	☑ Joint Stiffness
	☑ Joint Swelling	☑ muscle spasms good control Zanaflex.	☑ Neck Pain
Genitourinary/Nephrology:	☐ Flank Pain	☐ Blood in Urine	☐ Painful Urination
	☐ Decreased Urine Flow/Frequency/Volume		
Neurological:	☐ Dizziness	☐ Headaches	☐ Tremors
	☑ Numbness/Tingling good control Neurontin		☐ Seizures
Psychiatric:	☐ Depressed Mood	☐ Feeling Anxious	☐ Stress Problems
	☐ Suicidal Thoughts	☐ Suicidal Planning	
	☐ Thoughts of Harming Others		

☑ All other review of systems negative

☑ Reviewer JDC. 7-18-16

Brief Pain Inventory (Short Form)

Study ID# _____ Hospital# 10-14-80

Do not write above this line

Date: 6-21-16 Time: 10:30

Name: ~~Michelle~~ Smith Michelle

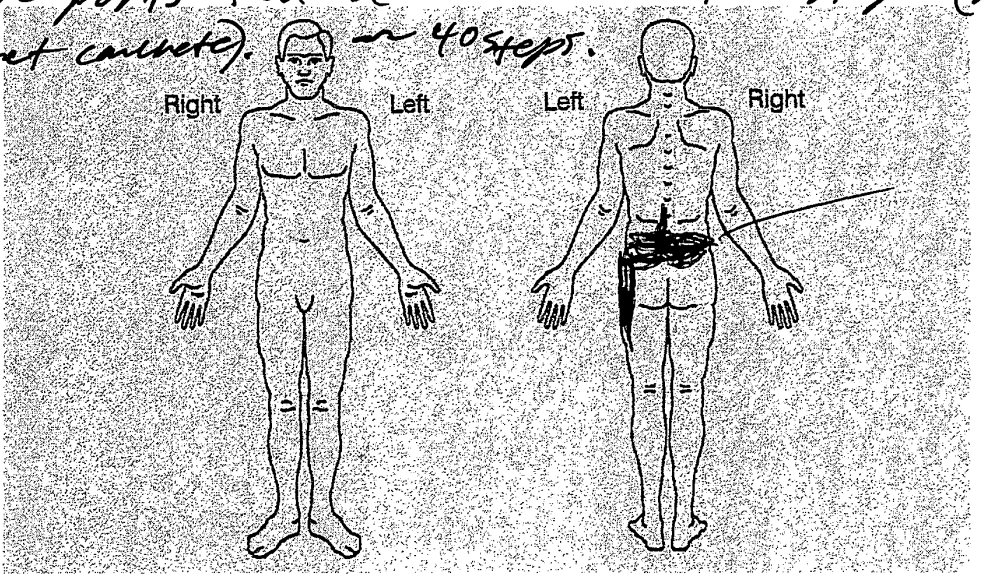
Last First Middle Initial

1) Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these ~~everyday~~ kinds of pain today?

1. Yes 2. No

2) On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.

• Pt reports fall down concrete steps (slipped on wet concrete). ~ 40 steps.



3) Please rate your pain by circling the one number that best describes your pain at its WORST in the past 24 hours.

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as you can imagine

4) Please rate your pain by circling the one number that best describes your pain at its LEAST in the past 24 hours.

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as you can imagine

5) Please rate your pain by circling the one number that best describes your pain on the AVERAGE.

0	1	2	3	4	5	6	(7)	8	9	10
No pain										Pain as bad as you can imagine

6) Please rate your pain by circling the one number that tells how much pain you have RIGHT NOW.

0	1	2	3	4	5	(6)	7	8	9	10
No pain										Pain as bad as you can imagine

#120 - Q;D.

7) What treatments or medications are you receiving for your pain?

roxycotin 30mg. Pt did not have other Rx this month d/t cost & inability to afford.

8) In the past 24 hours, how much relief have pain treatments or medications provided? Please circle the one percentage that most shows how much RELIEF you have received.

0%	10%	20%	30%	40%	50%	(60%)	70%	80%	90%	100%
No relief										Complete relief

9) Circle the one number that describes how, during the past 24 hours, pain has interfered with your:

A. General activity:

0	1	2	3	4	5	(6)	7	8	9	10
Does not interfere										Completely interferes

B. Mood:

0	1	2	3	4	5	(6)	7	8	9	10
Does not interfere										Completely interferes

C. Walking ability:

0	1	2	3	4	(5)	6	7	8	9	10
Does not interfere										Completely interferes

D. Normal work (includes both work outside the home and housework):

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

E. Relations with other people:

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

F. Sleep:

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

G. Enjoyment of life:

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

Review of Systems

Mark the following symptoms that you currently suffer from:

Constitutional:	☐ Chills	☐ Difficulty sleeping	☐ Easy bruising
	☐ Night Sweats	☐ Fatigue	☐ Fevers
	☐ Insomnia	☐ Low sex drive	☐ Tremors
	☐ Unexplained Weight Gain		☐ Weakness
	☐ Unexplained Weight Loss		
Eyes:	☐ Recent Visual changes		
Ears/Nose/Throat/Neck:	☐ Dental Problems	☐ Earaches	☐ Hearing Problems
	☐ Nosebleeds	☐ Sinus problems	
Cardiovascular:	☐ Chest Pain	☐ Bleeding Disorder	☐ Blood Clots
	☐ Fainting	☐ Palpitations	☐ Swelling in feet
	☐ Shortness of breath during sleep		
Respiratory:	☐ Cough	☐ Wheezing	☐ Shortness of breath
Gastrointestinal:	☐ Constipation	☐ Acid Reflux	☐ Abdominal Cramps
	☐ Diarrhea	☐ Nausea/Vomiting	☐ Hernia
Musculoskeletal:	☒ Back Pain	☒ Joint Pains	☒ Joint Stiffness
poorly-controlled pain + esp. lost ground d/t fall.	☐ Joint Swelling	☒ muscle spasms worsened & lacerations.	☐ Neck Pain
Genitourinary/Nephrology:	☐ Flank Pain	☐ Blood in Urine	☐ Painful Urination
	☐ Decreased Urine Flow/Frequency/Volume		
Neurological:	☐ Dizziness	☐ Headaches	☐ Tremors
	☒ Numbness/Tingling worsened & weakness.		☐ Seizures
Psychiatric:	☐ Depressed Mood	☐ Feeling Anxious	☐ Stress Problems
	☐ Suicidal Thoughts	☐ Suicidal Planning	
	☐ Thoughts of Harming Others		

☑ All other review of systems negative

☑ Reviewer JTO. 6.21.16

Brief Pain Inventory (Short Form)

Study ID# _____ Hospital# 10.14.80

Do not write above this line

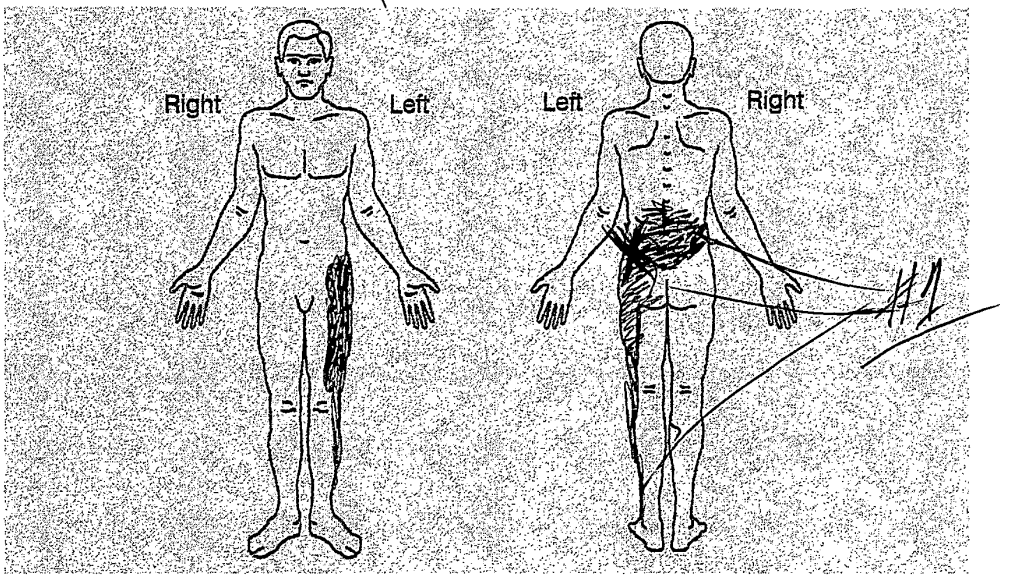
Date: 5-23-16 Time: ~~10~~ 9:50

Name: Smith (Last) Michelle (First) _____ (Middle Initial)

1) Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?

1. Yes 2. No

2) On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.



3) Please rate your pain by circling the one number that best describes your pain at its WORST in the past 24 hours.

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as you can imagine

4) Please rate your pain by circling the one number that best describes your pain at its LEAST in the past 24 hours.

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as you can imagine

5) Please rate your pain by circling the one number that best describes your pain on the AVERAGE.

0	1	2	3	4	(5)	6	7	8	9	10
No pain										Pain as bad as you can imagine

6) Please rate your pain by circling the one number that tells how much pain you have RIGHT NOW.

0	1	2	(3)	4	5	6	7	8	9	10
No pain										Pain as bad as you can imagine

did not fill d/t ~~no~~ neither pharmacy would fill it.

#120 PRN 6-8°S BID

7) What treatments or medications are you receiving for your pain?

Oxycodone 30 mg, Zoraflexor = Diflacanec, roratiptalene

8) In the past 24 hours, how much relief have pain treatments or medications provided? Please circle the one percentage that most shows how much RELIEF you have received. Motrin OTC 2 tabs BiD-TiD, Tylenol ES 2 tabs 1-4/day

0%	10%	20%	30%	40%	50%	60%	70%	(80%)	90%	100%
No relief										Complete relief

9) Circle the one number that describes how, during the past 24 hours, pain has interfered with your:

A. General activity:

0	1	2	3	(4)	5	6	7	8	9	10
Does not interfere										Completely interferes

B. Mood:

0	1	2	3	4	(5)	6	7	8	9	10
Does not interfere										Completely interferes

C. Walking ability:

0	1	2	(3)	4	5	6	7	8	9	10
Does not interfere										Completely interferes

D. Normal work (includes both work outside the home and housework):

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

E. Relations with other people:

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

F. Sleep:

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

G. Enjoyment of life:

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

Review of Systems

Mark the following symptoms that you currently suffer from:

Constitutional:	☐ Chills	☐ Difficulty sleeping	☐ Easy bruising
	☐ Night Sweats	☐ Fatigue	☐ Fevers
	☐ Insomnia	☐ Low sex drive	☐ Tremors
	☐ Unexplained Weight Gain		☐ Weakness
	☐ Unexplained Weight Loss		
Eyes:	☐ Recent Visual changes		
Ears/Nose/Throat/Neck:	☐ Dental Problems	☐ Earaches	☐ Hearing Problems
	☐ Nosebleeds	☐ Sinus problems	
Cardiovascular:	☐ Chest Pain	☐ Bleeding Disorder	☐ Blood Clots
	☐ Fainting	☐ Palpitations	☐ Swelling in feet
	☐ Shortness of breath during sleep		
Respiratory:	☐ Cough	☐ Wheezing	☐ Shortness of breath
Gastrointestinal:	☐ Constipation	☐ Acid Reflux	☐ Abdominal Cramps
	☐ Diarrhea	☐ Nausea/Vomiting	☐ Hernia
Musculoskeletal:	☐ Back Pain	☐ Joint Pains	☐ Joint Stiffness
- mod-controlled pain this month -	☐ Joint Swelling	☑ muscle spasms	☐ Neck Pain
Genitourinary/Nephrology:	☐ Flank Pain	☐ Blood in Urine	☐ Painful Urination
	☐ Decreased Urine Flow/Frequency/Volume		
Neurological:	☐ Dizziness	☐ Headaches	☐ Tremors
	☐ Numbness/Tingling — good control		☐ Seizures
	neuropathy - all this month.		
Psychiatric:	☐ Depressed Mood	☐ Feeling Anxious	☐ Stress Problems
	☐ Suicidal Thoughts	☐ Suicidal Planning	
	☐ Thoughts of Harming Others		

☑ All other review of systems negative

☐ Reviewer JDO. 5-23-16

Brief Pain Inventory (Short Form)

Study ID# _____ Hospital# 10-14-80

Do not write above this line

Date: 4-25-16 Time: 10:00 AM

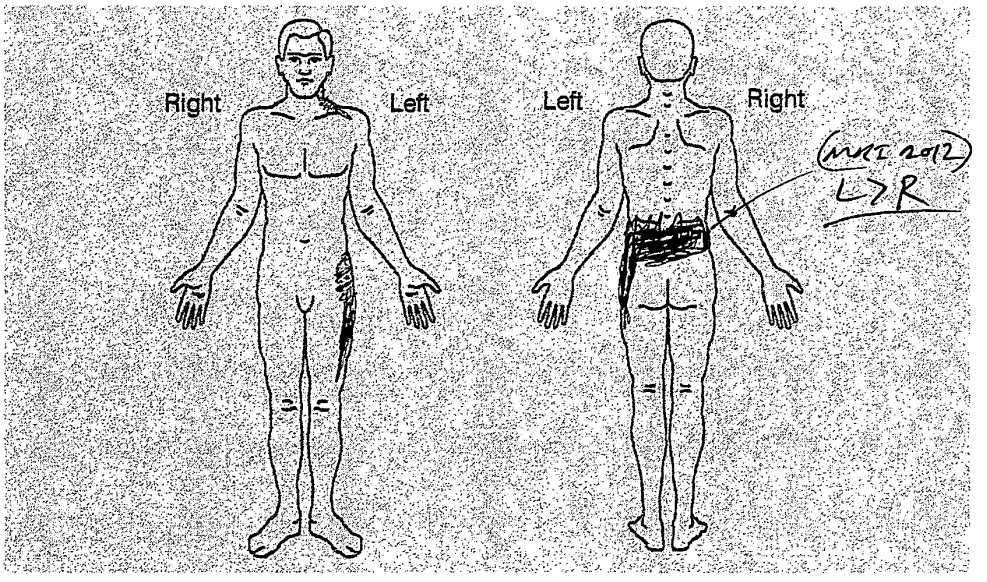
Name: Smith Michelle

Last First Middle Initial

1) Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?

1. ~~Yes~~ 2. No

2) On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.



3) Please rate your pain by circling the one number that best describes your pain at its WORST in the past 24 hours.

0	1	2	3	4	5	6	(7)	8	9	10
No pain										Pain as bad as you can imagine

4) Please rate your pain by circling the one number that best describes your pain at its LEAST in the past 24 hours.

0	1	2	(3)	4	5	6	7	8	9	10
No pain										Pain as bad as you can imagine

5) Please rate your pain by circling the one number that best describes your pain on the AVERAGE.

0	1	2	3	(4)	5	6	7	8	9	10
No pain										Pain as bad as you can imagine

6) Please rate your pain by circling the one number that tells how much pain you have RIGHT NOW.

0	1	2	3	4	5	(6)	7	8	9	10
No pain										Pain as bad as you can imagine

Neurontin 400mg QiD 2pills 1pills BiD PRN

7) What treatments or medications are you receiving for your pain?

OCIR roxycotin 30mg x 4 / zanaflex, noritriptyn / Diflecan c Zantac.

8) In the past 24 hours, how much relief have pain treatments or medications provided? Please circle the one percentage that most shows how much RELIEF you have received.

0%	10%	20%	30%	40%	50%	60%	70%	80%	(90%)	100%
No relief										Complete relief

9) Circle the one number that describes how, during the past 24 hours, pain has interfered with your:

A. General activity:

0	1	2	3	(4)	5	6	7	8	9	10
Does not interfere										Completely interferes

B. Mood:

0	1	2	3	(4)	5	6	7	8	9	10
Does not interfere										Completely interferes

C. Walking ability:

0	1	2	3	(4)	5	6	7	8	9	10
Does not interfere										Completely interferes

Review of Systems

Mark the following symptoms that you currently suffer from: insomnia thru night 5 OP6R

Constitutional:	☐ Chills	☑ Difficulty sleeping	☐ Easy bruising
	☐ Night Sweats	☐ Fatigue	☐ Fevers
	☐ Insomnia	☐ Low sex drive	☐ Tremors
	☐ Unexplained Weight Gain		☐ Weakness
	☐ Unexplained Weight Loss		
Eyes:	☐ Recent Visual changes		
Ears/Nose/Throat/Neck:	☐ Dental Problems	☐ Earaches	☐ Hearing Problems
	☐ Nosebleeds	☐ Sinus problems	
Cardiovascular:	☐ Chest Pain	☐ Bleeding Disorder	☐ Blood Clots
	☐ Fainting	☐ Palpitations	☐ Swelling in feet
	☐ Shortness of breath during sleep		
Respiratory:	☐ Cough	☐ Wheezing	☐ Shortness of breath
Gastrointestinal:	☐ Constipation	☐ Acid Reflux	☐ Abdominal Cramps
	☐ Diarrhea	☐ Nausea/Vomiting	☐ Hernia
Musculoskeletal:	☐ Back Pain	☑ Joint Pains	☑ Joint Stiffness
	☐ Joint Swelling	☑ muscle spasms	☐ Neck Pain
Genitourinary/Nephrology:	☐ Flank Pain	☐ Blood in Urine	☐ Painful Urination
	☐ Decreased Urine Flow/Frequency/Volume		
Neurological:	☐ Dizziness	☐ Headaches	☐ Tremors
	☑ Numbness/Tingling		☐ Seizures
Psychiatric:	☐ Depressed Mood	☐ Feeling Anxious	☐ Stress Problems
	☐ Suicidal Thoughts	☐ Suicidal Planning	
	☐ Thoughts of Harming Others		

☑ All other review of systems negative

☐ Reviewer _____ 10-04-25-16

D. Normal work (includes both work outside the home and housework):

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

E. Relations with other people:

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

F. Sleep:

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

G. Enjoyment of life:

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

Reference: Brief Pain Inventory. Charles Cleeland, PhD. Pain Research Group. Copyright 1991. Used with permission.

Pt takes Lortab. Rx well 5 issue. She indicates better/longer control of pain C OPTR.

A/P: G89.21, G89.4: Cont. this unit as written. Pt could pharmacy supply/ intolerable issues.

12.20.4.25-16 A7012-AS-8

Brief Pain Inventory (Short Form)

Study ID# _____ Hospital# 10-14-80
Do not write above this line 606-354-9640

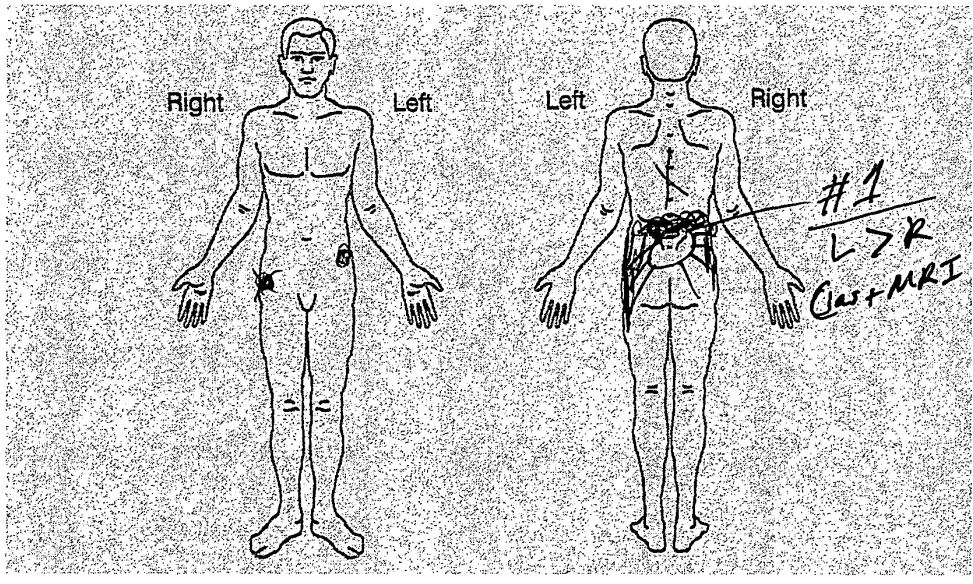
Date: 3-24-16 Time: 12:30

Name: Smith Michelle
Last First Middle Initial

1) Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?

1. Yes 2. No

2) On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.



3) Please rate your pain by circling the one number that best describes your pain at its WORST in the past 24 hours.

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as you can imagine

4) Please rate your pain by circling the one number that best describes your pain at its LEAST in the past 24 hours.

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as you can imagine

5) Please rate your pain by circling the one number that best describes your pain on the AVERAGE.

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as you can imagine

3 c Rx

6) Please rate your pain by circling the one number that tells how much pain you have RIGHT NOW.

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as you can imagine

Diclofenac BiD, Zantac BiD

BiD

OCIR #30 PRN SBP (stopped working)

7) What treatments or medications are you receiving for your pain?

Oxymorphone 30mg | roxycotin · 10mg | neurotonin - 400mg TiD | Zanaflex 4mg BiD

8) In the past 24 hours, how much relief have pain treatments or medications provided? Please circle the one percentage that most shows how much RELIEF you have received.

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
No relief										Complete relief

70% c Rx.

9) Circle the one number that describes how, during the past 24 hours, pain has interfered with your:

A. General activity:

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

B. Mood:

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

C. Walking ability:

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

D. Normal work (includes both work outside the home and housework):

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

E. Relations with other people:

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

F. Sleep: ~4° sleep/night ; 2-3 awakenings/night d/t pain.

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

G. Enjoyment of life:

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

Reference: Brief Pain Inventory. Charles Cleeland, PhD. Pain Research Group. Copyright 1991. Used with permission.

Pt takes & tol. Rx well 5 issue. Reports cont'd difficulty controlling pain in mid-day while working 12° shifts 5 days/wk as Hospital kitchen Supervisor. Her pharmacy will be out of opana until 4/15/16 per pharmacist I spoke with.

A/P: G89.21 : Δ to OCIR 30mg QiD for this month only until pharmacy is re-stocked.
- ↑ Neurontin 400mg QiD to better control N/T in legs. Rx ε refills called to CVS South Williamsburg KY.

I.D.-O.
3-24-16

A7012-AS-8

Review of Systems

Mark the following symptoms that you currently suffer from: improved somewhat c Rx.

Constitutional:	☐ Chills	☑ Difficulty sleeping	☐ Easy bruising
	☐ Night Sweats	☐ Fatigue	☐ Fevers
	☒ Insomnia	☐ Low sex drive	☐ Tremors
	☐ Unexplained Weight Gain		☐ Weakness
	☐ Unexplained Weight Loss		
Eyes:	☐ Recent Visual changes none		
Ears/Nose/Throat/Neck:	☐ Dental Problems	☐ Earaches	☐ Hearing Problems
	☐ Nosebleeds	☐ Sinus problems	
Cardiovascular:	☐ Chest Pain	☐ Bleeding Disorder	☐ Blood Clots
	☐ Fainting	☐ Palpitations	☐ Swelling in feet
	☐ Shortness of breath during sleep		
Respiratory:	☐ Cough	☐ Wheezing	☐ Shortness of breath
Gastrointestinal:	☐ Constipation	☐ Acid Reflux well-controlled c Zantac B.I.D.	☐ Abdominal Cramps
	☐ Diarrhea	☐ Nausea/Vomiting	☐ Hernia
Musculoskeletal:	☒ Back Pain	☐ Joint Pains	☒ Joint Stiffness
mod-control c current Rx.	☐ Joint Swelling	☒ muscle spasms improved c Zanaflex.	☐ Neck Pain
Genitourinary/Nephrology:	☐ Flank Pain	☐ Blood in Urine	☐ Painful Urination
	☐ Decreased Urine Flow/Frequency/Volume		
Neurological:	☐ Dizziness	☐ Headaches	☐ Tremors
	☒ Numbness/Tingling- less-mod-control c Neurontin.		☐ Seizures
Psychiatric:	☐ Depressed Mood	☐ Feeling Anxious	☐ Stress Problems
	☐ Suicidal Thoughts	☐ Suicidal Planning	
	☐ Thoughts of Harming Others		

☑ All other review of systems negative ☑ Reviewer J.D. 3.24.16

Dr. Smithers
Doctor
445 Commonwealth Blvd East
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Ste A, Martinsville, VA 24112
Address
276-226-2282
Phone

MEDICAL EXCUSE NOTE

Date 3-24-16

This certifies that Michelle Smith

has been/will be seen in this office for professional medical attention:

Date 3-24-16
Time 1430

We urge employers and schools to consider this an excused absence.

Notes:

J, D.C.

Signature J, D.C.

MICHELLE SMITH, 35 Years Old (West Virginia, Kentucky, North Carolina)

MICHELLE SMITH (12/01/2001 to 08/06/2015)

SSN: **407-19-2294**
Issued: **KENTUCKY 1983**

Date of Birth
DOB: **10/14/1980**
Age: **35**

Possible Relatives
None found

Indicators
Bankruptcies: **None Found**
Liens: **None Found**
Judgments: **None Found**
Utilities: **1 Found**

Cities
Pinsonfork, KY (11/15/2009 to 07/2015)
Hickory, NC (01/2002 to 06/2002)
Rawl, WV (10/01/2001 to 08/06/2015)

Counties
Pike County, KY (11/15/2009 to 07/2015)
Burke County, NC (01/2002 to 06/2002)
Mingo County, WV (10/01/2001 to 08/06/2015)

Possible Other Phones
(606) 353-9640 (ET) (LandLine)(100%)
(606) 353-1096 (ET)(66%)
(606) 353-4797 (ET) (LandLine)(66%)
(606) 353-5347 (ET)(66%)
(606) 625-1952 (ET) (Mobile)(66%)
(304) 235-0168 (ET)(3%)

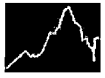
Possible Emails
hbmah@aol.com
hbmah@bellsouth.net

Address History (3)

294 RUNYON BRANCH RD, PINSONFORK, KY 41555-7402 (PIKE COUNTY) (11/15/2009 to Present)
1 Current Private Phone
Possible Subject's Phone
(606) 353-9640(ET) - SMITH, MICHALLE

PO BOX 102, RAWL, WV 25691-0102 (MINGO COUNTY) (10/01/2001 to 11/06/2015)

9304 COSTNER RD, HICKORY, NC 28602-8666 (BURKE COUNTY) (01/2002 to 06/2002)
1 Current Private Phone
Current Private Phone at address
(828) 397-3178(ET) - KELLER, RUBY



Department of Health Professions

Phone:(804)367-4566 Email:pmp@dhp.virginia.gov Fax:(804)527-4470

Patient RX History Report

This report may contain another person's controlled substance information. Please review the "Patients that Match Search Criteria" section located below to ensure all prescriptions belong to the requested individual.

Original Search Criteria Modified
Search Criteria:((Last Name Begins 'smith' AND First Name Contains 'Michelle') AND (D.O.B = '10/14/1980' AND Street = '1016 vinson st')) AND Request Period = '11/30/2014' To '11/30/2015'

Patients that match search criteria

Pt ID	Name	DOB	Address

No results found from [38] for your patient search

No results found from [IN] for your patient search

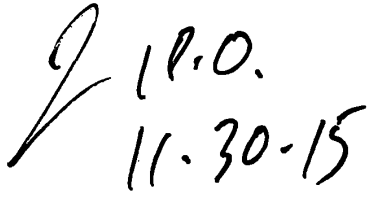
No results found from [KY] for your patient search

No results found from [OH] for your patient search

No results found from [SC] for your patient search

No results found from [TN] for your patient search

No results found from [WV] for your patient search



Disclaimer: The Commonwealth of Virginia does not warrant the above information to be accurate or complete. The Report is based on the search criteria entered and the data entered by the dispensing pharmacy. For more information about any prescription, please contact the dispensing pharmacy or the prescriber.

CABINET FOR HEALTH AND FAMILY SERVICES
Commonwealth of Kentucky
275 East Main Street
Frankfort, KY 40621-0001
Drug Enforcement Branch - KASPER
Patient Controlled Substance Report
Between 11/28/2014 and 11/28/2015

Requestor Name : MEHTA SANJAY
Request # : 22153056

Patient Name: Smith, Michelle **SSN:** 407-19-2294 **DOB:** 10/14/1980

Date Filled	Drug Name	Patient DOB	Qty	Days	Prescriber Name	Prescriber DEA City	Pharmacy Name	Pharmacy City	Rpt To	Pat ID

No records were found for the date range or information provided. If you feel this is in error you may wish to take one or more of the following action(s):

(1) Request the report again, providing more specific criteria (SSN, DOB, Alias or Additional Address) and/or expanding the date range beyond the requested time period.
(2) Contact the Drug Enforcement and Professional Practices Branch for additional information at (502) 564-7985.

I.D.O.
11-30-15

**The information in this report is based upon Schedule II through V controlled substance records reported by dispensers. Data should appear on KASPER reports within two to three business days after dispensing.*
**The records listed in the report are based on the patient identification information entered by the report requestor, and if not sufficiently unique may result in the report including records for multiple patients. Please verify the information in the report by contacting the prescribers and/or dispensers listed.*
**If the controlled substance records on this report appear to be in error, the patient or provider should contact the dispenser to determine if the information was reported accurately. If the dispenser certifies the information was reported accurately, the dispenser can contact the Drug Enforcement and Professional Practices Branch at 502-564-7985 to investigate the error.*
**The information in this report is intended for informational use only by the person authorized to request the report. Intentional disclosure of the report or data to someone not authorized to obtain the data is a Class B Misdemeanor.*

Report Restrictions – A practitioner or pharmacist may share the report with the patient or person authorized to act on the patient's behalf and place the report in the patient's medical record, with the report then being deemed a medical record subject to the same disclosure terms and conditions as an ordinary medical record. (KRS 218A.202)

Scrip[illegible] of 7
48020151130212026187
November 30, 2015

Patient: Smith, Michelle 10-14-80 Age: 35
Address:
Dx: 719.40.
Provider: Joel Smithers, DO
Address: 445 Commonwealth Blvd E Ste A
Martinsville, VA 24112
Phone: (276)226-2282
DEA#: FS4850459 NPI: 1659639631

Rx
Diclofenac Sodium
Oral Tablet Delayed Release
75 Milligram
1 TABLET TWICE DAILY AS NEEDED FOR PAIN
WITH FOOD WATER & ZANTAC
Dispense Amount: 60 (Sixty) Tablets
Subs Permitted: Yes
Refill: 3 (Three) times
Pharmacist: Please dispense appropriate size/amounts.

Joel Smithers, DO
State ID: WV2913 VA[illegible]102204264

TO AUTHENTICATE: "VOID" PANTOGRAPH - BATCH # MP1150623562 MULTIPLE SECURITY FEATURES: COLORED BACKGROUND, REVERSE Rx. SCRATCH BACK WITH COIN TO

BATCH # MP1150623562

Scrip[illegible]of 7
48020151130212026316
November 30, 2015

Patient: Smith, Michelle Age: 35
Address:

Provider: Joel Smithers, DO
Address: 445 Commonwealth Blvd E Ste A
Martinsville, VA 24112
Phone: (276)226-2282
DEA#: FS4850459 NPI: 1659639631

℞ Ranitidine HCl
Oral Tablet
150 Milligram
1 TABLET TWICE DAILY PRN HEARTBURN,
REFLUX
Dispense Amount: 60 (Sixty) Tablets
Subs Permitted: Yes
Refill: 6 (Six) times
Pharmacist: Please dispense appropriate size/amounts.

Joel Smithers, DO
State ID: WV2913 VA0102204264

ICATE - "VOID" PANTOGRAPH - BATCH # MFI1502556502 - MULTIPLE SECURITY FEATURES: COLORED BACKGROUND, REVERSE Rx, SCRATCH BACK WITH COIN TO AUTHENT

BATCH # MFI1502556502

Scrip[illegible]of 7
48020151130212026437
November 30, 2015

Patient: Smith, Michelle Age: 35
Address:

DR: 728.95.

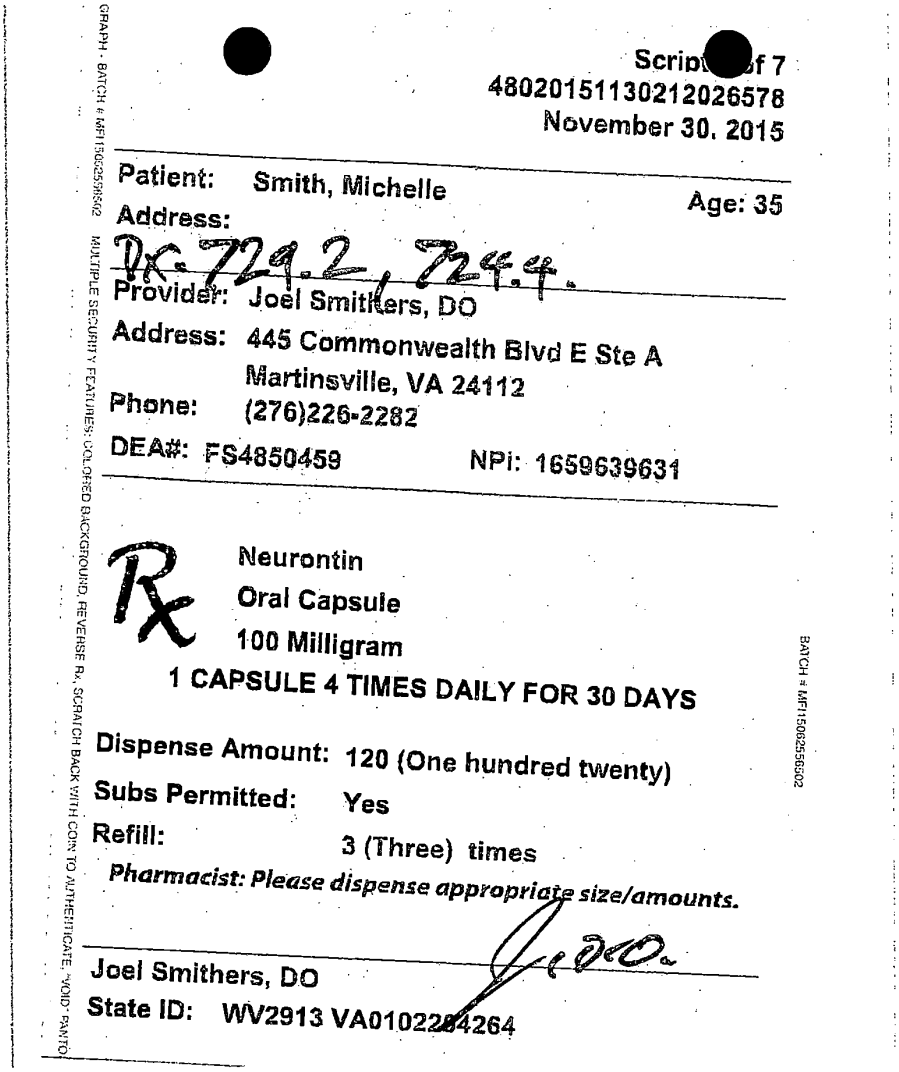
Provider: Joel Smithers, DO
Address: 445 Commonwealth Blvd E Ste A
Martinsville, VA 24112
Phone: (276)226-2282
DEA#: FS4850459 NPI: 1659639631

℞
Zanaflex
Oral Tablet
4 Milligram
1-2 TABLETS AT BEDTIME AS NEEDED FOR SPASMS/PAIN
Dispense Amount: 60 (Sixty) Tablets
Subs Permitted: Yes
Refill: 6 (Six) times
Pharmacist: Please dispense appropriate size/amounts.

Joel Smithers, DO
State ID: WV2913 VA0102204264

VOID" PANTOGRAPH - BATCH # MP1506255602 - MULTIPLE SECURITY FEATURES: COLORED BACKGROUND, REVERSE Rx, SCRATCH BACK WITH COIN TO AUTHENTICATE. VC

BATCH # MP1506255602



Scrip[illegible] of 7
48020151130212026578
November 30, 2015

Patient: Smith, Michelle Age: 35
Address:

Dx. 729.2, 724.4.

Provider: Joel Smithers, DO
Address: 445 Commonwealth Blvd E Ste A
Martinsville, VA 24112
Phone: (276)226-2282
DEA#: FS4850459 NPI: 1659639631

Rx
Neurontin
Oral Capsule
100 Milligram
1 CAPSULE 4 TIMES DAILY FOR 30 DAYS

Dispense Amount: 120 (One hundred twenty)
Subs Permitted: Yes
Refill: 3 (Three) times
Pharmacist: Please dispense appropriate size/amounts.

Joel Smithers, DO
State ID: WV2913 VA0102284264

GRAPH - BATCH # MF1150623556502 MULTIPLE SECURITY FEATURES: COLORED BACKGROUND, REVERSE Rx, SCRATCH BACK WITH COIN TO AUTHENTICATE, "VOID" PANTO

BATCH # MF1150623556502

Scrip of 7
48020151130212026698
November 30, 2015

Patient: Smith, Michelle Age: 35
Address:
Dx: 729.2, 729.85.
Provider: Joel Smithers, DO
Address: 445 Commonwealth Blvd E Ste A
Martinsville, VA 24112
Phone: (276)226-2282
DEA#: FS4850459 NPI: 1659639631

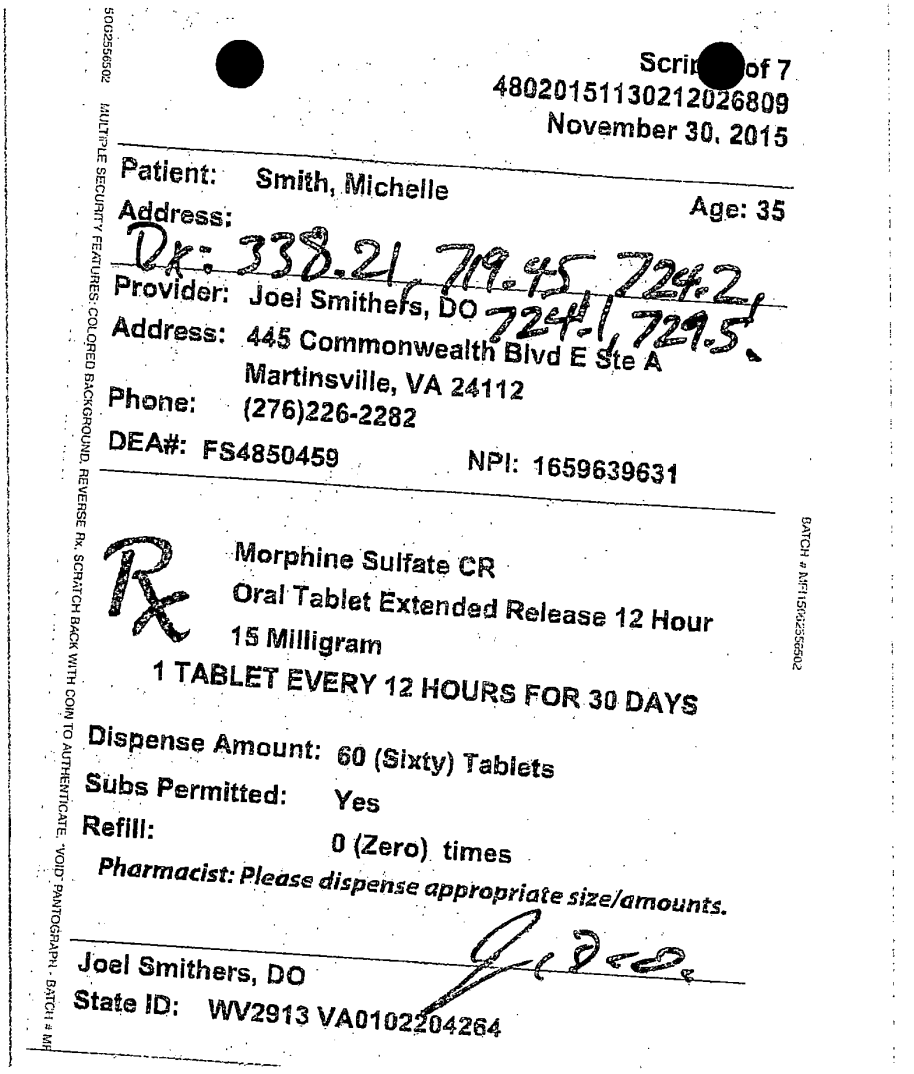
Rx
Nortriptyline HCl
Oral Capsule
25 Milligram
1 CAPSULE AT BEDTIME.

Dispense Amount: 60 (Sixty) Capsules
Subs Permitted: Yes
Refill: 6 (Six) times
Pharmacist: Please dispense appropriate size/amounts.

Joel Smithers, DO
State ID: WV2913 VA0102204264

ITCH # MF1596255502 MULTIPLE SECURITY FEATURES. COLORED BACKGROUND. REVERSE Rx. SCRATCH BACK WITH COIN TO AUTHENTICATE. "VOID" PANTOGRAPH - BI

BATCH # MF1596255502



Scri[redacted] of 7
48020151130212026809
November 30, 2015

Patient: Smith, Michelle
Address: Age: 35

Dx: 338.21, 719.45, 724.2, 724.1, 729.5

Provider: Joel Smithers, DO
Address: 445 Commonwealth Blvd E Ste A
Martinsville, VA 24112
Phone: (276)226-2282
DEA#: FS4850459 NPI: 1659639631

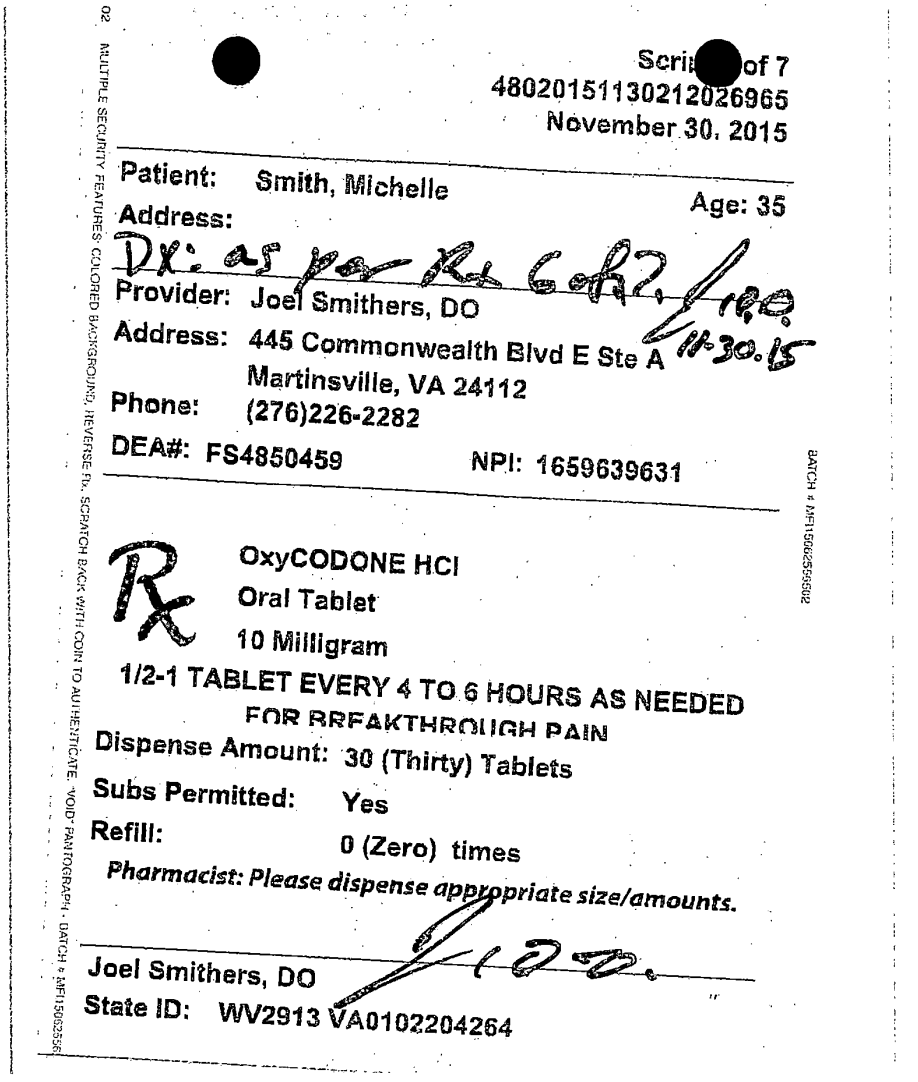
Rx
Morphine Sulfate CR
Oral Tablet Extended Release 12 Hour
15 Milligram
1 TABLET EVERY 12 HOURS FOR 30 DAYS

Dispense Amount: 60 (Sixty) Tablets
Subs Permitted: Yes
Refill: 0 (Zero) times
Pharmacist: Please dispense appropriate size/amounts.

Joel Smithers, DO
State ID: WV2913 VA0102204264

5062556502 MULTIPLE SECURITY FEATURES: COLORED BACKGROUND. REVERSE Rx. SCRATCH BACK WITH COIN TO AUTHENTICATE. "VOID" PANTOGRAPH. - BATCH # MF

BATCH # MF1156062556502



Scri[redacted] of 7
48020151130212026965
November 30, 2015

Patient: Smith, Michelle Age: 35
Address:
Dx: as per Rx Coh2. 1100. 11-30-15
Provider: Joel Smithers, DO
Address: 445 Commonwealth Blvd E Ste A
Martinsville, VA 24112
Phone: (276)226-2282
DEA#: FS4850459 NPI: 1659639631

Rx
OxyCODONE HCl
Oral Tablet
10 Milligram
1/2-1 TABLET EVERY 4 TO 6 HOURS AS NEEDED FOR BREAKTHROUGH PAIN
Dispense Amount: 30 (Thirty) Tablets
Subs Permitted: Yes
Refill: 0 (Zero) times
Pharmacist: Please dispense appropriate size/amounts.

Joel Smithers, DO 11-30-15
State ID: WV2913 VA0102204264

MULTIPLE SECURITY FEATURES: COLORED BACKGROUND, REVERSE Rx, SCRATCH BACK WITH COIN TO AUTHENTICATE, "VOID" PANTOGRAPH - BATCH # MF1506235

BATCH # MF1506255502

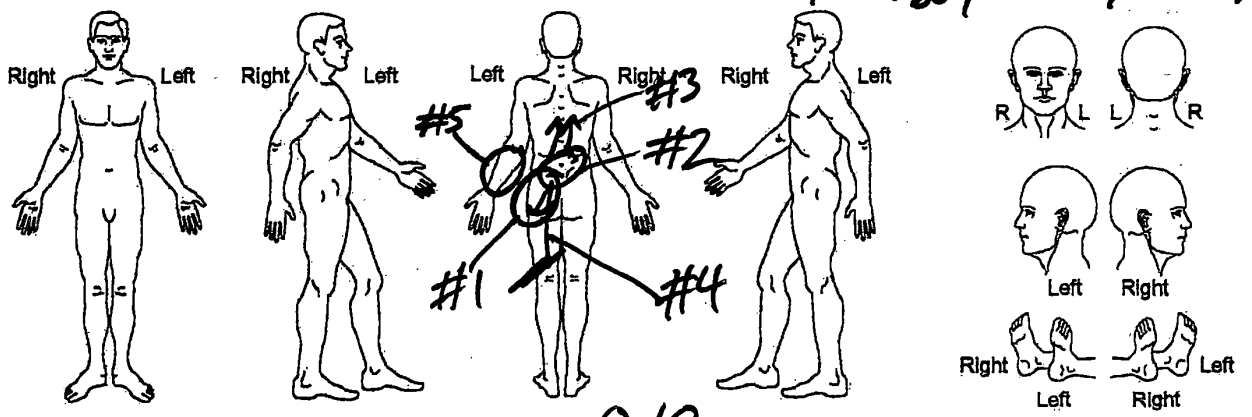
Form 1.1 Initial Pain Assessment Tool

Patient's Name Michelle Smith 10-14-80 Age 35 Date 11-30-15 Room I

Diagnosis 338.21, 719.45, 724.2, 724.4, 724.1, 729.2, 729.5, 728.85 Physician [illegible]

Nurse 155.8#'s, 122/86, HR65, 99%SpO2

1. LOCATION: Patient or nurse mark drawing.



2. INTENSITY: Patient rates the pain. Scale used 0-10

Present pain: 8 Worst pain gets: 9-10 Best pain gets: 3-4 Sometimes Acceptable level of pain: 5

3. IS THIS PAIN CONSTANT? ____ YES; X NO IF NOT, HOW OFTEN DOES IT OCCUR? "Intensity is variable but pain is always there."

4. QUALITY: (For example: ache, deep, sharp, hot, cold, like sensitive skin, sharp, itchy) _____

5. ONSET, DURATION, VARIATIONS, RHYTHMS: _____

6. MANNER OF EXPRESSING PAIN: _____

7. WHAT RELIEVES PAIN? _____

8. WHAT CAUSES OR INCREASES THE PAIN? _____

9. EFFECTS OF PAIN: (Note decreased function, decreased quality of life.)

Accompanying symptoms (e.g., nausea) _____

Sleep 4-5 awakenings/night d/t pain.

Appetite _____

Physical activity _____

Relationship with others (e.g., irritability) _____

Emotions (e.g., anger, suicidal, crying) _____

Concentration _____

Other Liver or kidney Dz. OSA COPD.

10. OTHER COMMENTS: Tubal in 2008.

11. PLAN: _____

Checklist for Long-Term Opioid Therapy

Patient name:_____

Workup	Date	Outcome
Complete medical history		
Complete physical examination		
Assessment of the pain		
Assessment of pain on physical and psychological function		
Assessment of history of substance abuse		
Assessment of Coexisting diseases or conditions		
Documentation on the presence of recognized medical indication for the use of a controlled substance		
Establish goals of opioid treatment		
Risks and benefits communicated		
Written consent or pain agreement (optional, if high risk or history of substance abuse)		
Periodic review of goals		
Monitor compliance		
Consultation as necessary for additional evaluation and treatment		
Accurate and complete records to include medical history, physical examinations, evaluations, consultations, treatment plan objectives, informed consent treatments, medications, rationale for changes in treatment plan, agreements with patient, and periodic reviews of the treatment plan		

Reference: Medical Board of California. Department of Consumer Affairs. Guidelines for prescribing controlled substances for pain (2007). http://www.mbc.ca.gov/Licensees/Prescribing/Pain_Guidelines.aspx. Accessed May 2014

C7012-AF-1W

Smithers Community Healthcare, PC
New Patient Intake Form for pain management

Your completed intake paperwork helps your physician and other providers get to know you and your medical history better. We rely on its accuracy and completeness to provide you with the best possible care. Please inquire at our front desk or call (844) 373-7883 if you have any question on how to complete any section on this form.

Patient Information

Today's date: 11-30-15

Your name: Michelle Smith Date of Birth: 10-14-1980 Age: 35

Referring Physician: _____ Primary Care Physician: Dr. Soma

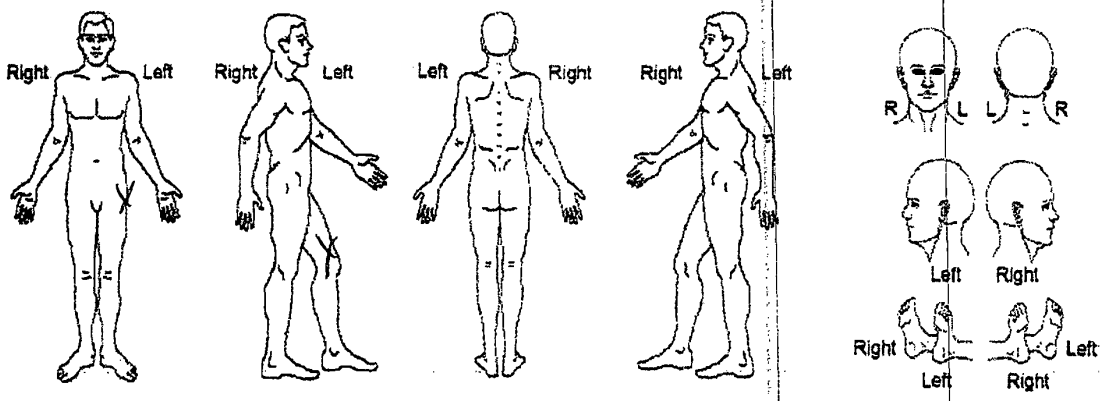
Pain History

Chief Complaint (Reason for your visit today)? Chronic pain lower back, hip

Does this pain radiate? If so where? left leg

Please list any additional areas of pain: _____

Use this diagram to indicate the area of your pain. Mark the location with an "X"



Onset of Symptoms

Approximately when did this pain begin? April 2015

What caused your current pain episode? Car wreck: MVA caused Fx to (L) forearm (radius) & severely sprained mid-LB & (L) hip & pain radiating into (L) leg, thigh.

How did your current pain episode begin? ☐ Gradually ☑ Suddenly

Since your pain began how has it changed? ☐ Improved ☑ Worsened ☐ Stayed the same

Pain Description

Check all of the following that describe your pain:

☑ Dull/Aching	☑ Hot/Burning	☐ Shooting	☐ Stabbing/Sharp
☐ Cramping	☐ Numbness	☐ Spasming	☐ Throbbing
☐ Squeezing	☐ Tingling/Pins and Needles		☐ Tightness

When is your pain at its worst?

☐ Mornings	☐ Daytime	☐ Evenings	☐ Middle of the night

☑ Always the same

How often does the pain occur?

☐ Constant ☑ Changes in severity but always present

☐ Intermittent (comes and goes)

If pain "0" is no pain and "10" is the worst pain you can imagine, how would you rate your pain?

Right Now_____ The Best It Gets_____ The Worst It Gets_____

Mark the effect each of the following have on your pain level - ☑

	Increases	Decreases	No Change
Bending Backward	☐	☐	☑
Bending Forward	☑	☐	☐
Changes in Weather	☑	☐	☐
Climbing Stairs	☑	☐	☐
Coughing/Sneezing	☐	☐	☑
Driving	☑	☐	☐
Lifting Objects	☑	☐	☐
Looking upward	☑	☐	☐
Looking downward	☐	☐	☑
Rising from seated position	☑	☐	☐
Sitting	☑	☐	☐
Standing	☑	☐	☐
Walking	☑	☐	☐

What other factors worsen or affect your pain which is not mentioned above?

Associated Symptoms

	NO	Yes	Comments
Numbness/Tingling	☐	☑	Where? hip / thigh
Weakness in the arm/leg	☑	☐	
Balance Problems	☑	☐	
Bladder Incontinence	☑	☐	
Bowel Incontinence	☑	☐	
Joint Swelling/Stiffness	☐	☑	
Fevers/chills	☑	☐	

Please mark all of the following treatments you have used for pain relief ☑

	No Change	Worsened Pain	Helped Pain
Spine Surgery	☐	☐	☐
Physical Therapy	☑	☐	☐
Chiropractic Care	☐	☐	☐
Psychological Therapy	☐	☐	☐
Brace Support	☐	☐	☐
Acupuncture	☐	☐	☐
Hot/Cold Packs	☑	☐	☐
Massage Therapy	☐	☐	☐
Medications	☐	☐	☐
TENS Unit	☐	☐	☐

Other _____

Interventional Pain Treatment History

☐ Epidural Steroid Injection – (circle all levels that apply) Cervical/Thoracic/Lumbar

☐ Joint Injection – Joint(s) _____

☐ Medial Branch Blocks/Facet Injections - (circle levels) Cervical/Thoracic/Lumbar

☐ MILD (Minimally Invasive Lumbar Decompression) - _____

☐ Nerve Blocks – Area/Nerve(s) - _____

☐ Radiofrequency Nerve Ablation – (circle levels) – Cervical/Thoracic/Lumbar

☐ Spinal Cord Stimulator – Trial Only/Permanent Implant _____

☐ Trigger Point Injections – Where? _____

☐ Vertebroplasty/Kyphoplasty – Level(s) _____

☐ Other - _____

Which of these procedures listed above have helped with your pain? _____

_____

Diagnostic Tests and Imaging

Mark all of the following tests that you have related to your current pain complaints:

☒ MRI of the: LB & Lsp Date: April 2015

☒ X-Ray of the: _____ Date: Apr. 2015

☐ CT Scan of the: _____ Date: _____

☐ EMG/NCV study of the: _____ Date: _____

☐ Other Diagnostic Testing: _____ Date: _____

☐ I have not had ANY diagnostic tests for my current pain complaint

Mark the following physicians or specialists you have consulted for your current pain problem(s):

☐ Acupuncturist	☐ Neurosurgeon	☐ Psychiatrist/Psychologist
☐ Chiropractor	☒ Orthopedic Surgeon	☐ Rheumatologist
☐ Internist	☒ Physical Therapist	☐ Neurologist

☐ Other _____

Past Medical History

Please list the names of other Pain Physicians you have seen in the past? none -

Mark the following conditions/diseases that you have been treated for in the past:

General Medical
- ☐ Cancer – Type _____
- ☐ Diabetes – Type_____

Cardiovascular/Hematologic
- ☐ Anemia
- ☐ Heart Attack
- ☐ Coronary Artery Disease
- ☐ High Blood Pressure
- ☐ Peripheral Vascular Disease
- ☐ Stoke/TIA
- ☐ Heart Valve Disorders

Gastrointestinal
- ☐ GERD (Acid Reflux)
- ☐ Gastrointestinal Bleeding
- ☐ Stomach Ulcers
- ☐ Constipation

Urological
- ☐ Chronic Kidney Disease
- ☐ Kidney Stones
- ☐ Urinary Incontinence
- ☐ Dialysis

Neuropsychological
- ☐ Multiple Sclerosis
- ☐ Peripheral Neuropathy
- ☐ Seizures
- ☐ Depression
- ☐ Anxiety
- ☐ Schizophrenia
- ☐ Bipolar Disorder

Head/Ears/Eyes/Nose/Throat
- ☐ Headaches
- ☐ Migraines
- ☐ Head Injury
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Glaucoma

Respiratory
- ☐ Asthma
- ☐ Bronchitis/Pneumonia
- ☐ Emphysema/COPD

Musculoskeletal/Rheumatologic
- ☐ Bursitis
- ☐ Carpal Tunnel Syndrome
- ☐ Fibromyalgia
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ Chronic Joint Pains

Other Diagnosed Conditions
- ☐ CLBP end.
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Past Surgical History

Please list any surgical procedures you have had done in the past including date:

1) ~~right~~ left Arm fracture Date? Apr. 2015
2) Tubal ligation Date? 6/2008
3) _____ Date? _____
4) _____ Date? _____
5) _____ Date? _____

☐ I have **NEVER** had any surgical procedures performed.

Current Medications

Are you currently taking any blood thinners or anti-coagulants? ☐ YES ~~☐ NO~~

If YES, which ones? ☐ Aspirin ☐ Plavix ☐ Coumadin ☐ Lovenox ☐ Other _____

Please list all medications you are currently taking including vitamins. Attach additional sheet if required:

	Medication Name	Dose	Frequency
1)	Advil ø	OTC	4 tabs/day
2)	Aleve	OTC	4 tabs/day
3)	ASA	325mg	4 tabs/day
4)	Tylenol ES	OTC	PRN 1-2/day
5)			
6)			
7)			
8)			
9)	(off all opiates for 2-3 wks).		
10)			

Please list all past pain medications that you have been on at any point for your current pain complaints?

	Medication Name	Dose	Frequency
1)	Neurontin	900mg	BID
2)	Norco ?	7.5mg/325mg	TID
3)	Lortab		
4)	Percocet	10/325mg	QID
5)	OC	15 → 7/day	BID

Allergies

Do you have any drug/medication allergies? ☐ Yes ☑ No

If so, please list all medications you are allergic to:

	Medication Name	Allergic Reaction
1)		
2)		
3)		
4)		
5)		

Topical Allergies: ☐ Latex ☐ Iodine ☐ Tape ☐ IV Contrast

Family History

Mark all appropriate diagnoses as they pertain to your first degree relatives:

☐ Arthritis ☒ Cancer – Brain (M). ☐ Diabetes

☐ Headaches/Migraines ☐ High Blood Pressure ☐ Kidney Problems

☐ Liver Problems ☐ Osteoporosis ☐ Rheumatoid arthritis

☐ Seizures ☐ Stroke

☐ Other Medical Problems: _____

☐ I have no significant family medical history

Social History

Occupation: Food Prod. Coord. When was the last time you worked? currently working

Who is in your current household? three children + myself

Are there any stairs in your current home? no If so how many? _____

☐ Temporary Disability ☐ Permanent Disability ☐ Retired ☐ Unemployed

Are you currently under worker's compensation? ☒ No ☐ Yes

Is there an ongoing lawsuit related to your visit today? ☒ No ☐ Yes

Alcohol Use:

☐ Social Use ☐ History of alcoholism ☐ Current alcoholism ☑ Never

☐ Daily use of alcohol

Tobacco Use:

☑ Current user ☐ Former user ☐ Never used

☐ Packs per day? 1 ☐ How many years? _____ ☐ Quit Date: _____

Illegal Drug Use:

☑ Denies any illegal drug use ☐ Currently uses illegal drugs

☐ Formerly used illegal drugs (not currently using)

Have you ever abused narcotic or prescription medications? ☐ Yes ☑ No

Review of Systems

Mark the following symptoms that you currently suffer from:

Constitutional:	☐ Chills	☑ Difficulty sleeping	☐ Easy bruising
	☐ Night Sweats	☑ Fatigue	☐ Fevers
	☐ Insomnia	☐ Low sex drive	☐ Tremors
	☐ Unexplained Weight Gain		☐ Weakness
	☐ Unexplained Weight Loss		
Eyes:	☐ Recent Visual changes		
Ears/Nose/Throat/Neck:	☐ Dental Problems	☐ Earaches	☐ Hearing Problems
	☐ Nosebleeds	☐ Sinus problems	
Cardiovascular:	☐ Chest Pain	☐ Bleeding Disorder	☐ Blood Clots
	☐ Fainting	☐ Palpitations	☐ Swelling in feet
	~~☐ Shortness of breath during sleep~~		
Respiratory:	☐ Cough	☐ Wheezing	☐ Shortness of breath
Gastrointestinal:	☐ Constipation	☐ Acid Reflux	☐ Abdominal Cramps
	☐ Diarrhea	☐ Nausea/Vomiting	☐ Hernia
Musculoskeletal:	☑ Back Pain	☑ Joint Pains (L hip)	☑ Joint Stiffness
	☐ Joint Swelling	☑ muscle spasms LL LB	☐ Neck Pain
Genitourinary/Nephrology:	☐ Flank Pain	☐ Blood in Urine	☐ Painful Urination
	☐ Decreased Urine Flow/Frequency/Volume		
Neurological:	~~☐ Dizziness~~	☐ Headaches occ: vomit.	~~☐ Tremors~~
	☑ Numbness/Tingling (L) hip & leg.		~~☐ Seizures~~
Psychiatric:	~~☐ Depressed Mood~~	~~☐ Feeling Anxious~~	~~☐ Stress Problems~~
	~~☐ Suicidal Thoughts~~	~~☐ Suicidal Planning~~	
	~~☐ Thoughts of Harming Others~~		

☑ All other review of systems negative

☑ Reviewer _____ 4.30.15

SOAPP®-R

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.

	Never 0	Seldom 1	Sometimes 2	Often 3	Very Often 4
1. How often do you have mood swings?	○	✓	○	○	○
2. How often have you felt a need for higher doses of medication to treat your pain?	○	○	○	✓	○
3. How often have you felt impatient with your doctors?	○	✓	○	○	○
4. How often have you felt that things are just too overwhelming that you can't handle them?	○	✓	○	○	○
5. How often is there tension in the home?	○	✓	○	○	○
6. How often have you counted pain pills to see how many are remaining?	○	○	○	○	○
7. How often have you been concerned that people will judge you for taking pain medication?	○	○	○	○	✓
8. How often do you feel bored?	○	✓	○	○	○
9. How often have you taken more pain medication than you were supposed to?	✓	○	○	○	○
10. How often have you worried about being left alone?	○	○	○	○	✓
11. How often have you felt a craving for medication?	✓	○	○	○	○
12. How often have others expressed concern over your use of medication?	✓	○	○	○	○

 The SOAPP®-R was developed with a grant from the National Institutes of Health and an educational grant from Endo Pharmaceuticals.

PainEDU

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
13. How often have any of your close friends had a problem with alcohol or drugs?	○	○	○	○	○
14. How often have others told you that you had a bad temper?	○	○	○	○	○
15. How often have you felt consumed by the need to get pain medication?	○	○	○	○	○
16. How often have you run out of pain medication early?	○	○	○	○	○
17. How often have others kept you from getting what you deserve?	○	○	○	○	○
18. How often, in your lifetime, have you had legal problems or been arrested?	○	○	○	○	○
19. How often have you attended an AA or NA meeting?	○	○	○	○	○
20. How often have you been in an argument that was so out of control that someone got hurt?	○	○	○	○	○
21. How often have you been sexually abused?	○	○	○	○	○
22. How often have others suggested that you have a drug or alcohol problem?	○	○	○	○	○
23. How often have you had to borrow pain medications from your family or friends?	○	○	○	○	○
24. How often have you been treated for an alcohol or drug problem?	○	○	○	○	○

Please include any additional information you wish about the above answers. Thank you.

PainEDU

The Center for Integrative Health
at Smithers Community Healthcare, P.C.
Joel A. Smithers, D.O.
DEA #: FS4850459 • LIC #: 0102204264
NPI #: 1659639631
445 Commonwealth Blvd East, Ste A
Martinsville, VA 24112
Tel: (276) 226-2282 • Fax: (844) 550-7109

Name. Michelle Smith DOB 10-11-50

Address. Dr. G [illegible] Date. 3-24-16

℞

Oxycodone 30mg (IR)
Sig: 1/2-1 tab q 6-8° PRN severe pain
Disp: #120 (one hundred twenty)

☐ Label

Refill__________times PRN NR

☐ Brand Medically Necessary

☒ Voluntary Formulary Permitted

[signature] D.O.

Signature of Prescriber

IF NEITHER BOX IS MARKED, A VOLUNTARY FORMULARY PRODUCT MUST BE DISPENSED

The Center for Integrative Health
at Smithers Community Healthcare, P.C.
Joel A. Smithers, D.O.
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NPI #: 1659639631
445 Commonwealth Blvd East, Ste A
Martinsville, VA 24112
Tel: (276) 226-2282 • Fax: (844) 550-7109

Fill date: 7-24-16

Name. Michelle Smith DOB 10-11-80

Address. Dx: G89.21 Date 7-18-16

℞

Oxycodone (IR)

5-1/2 T. q 12-24° PRN Relieve breakthrough pain

Disp # 40 (forty)

COPY

☐ Label

Refill__________times PRN NR

☐ Brand Medically Necessary

☑ Voluntary Formulary Permitted

______________________ D.O.

Signature of Prescriber

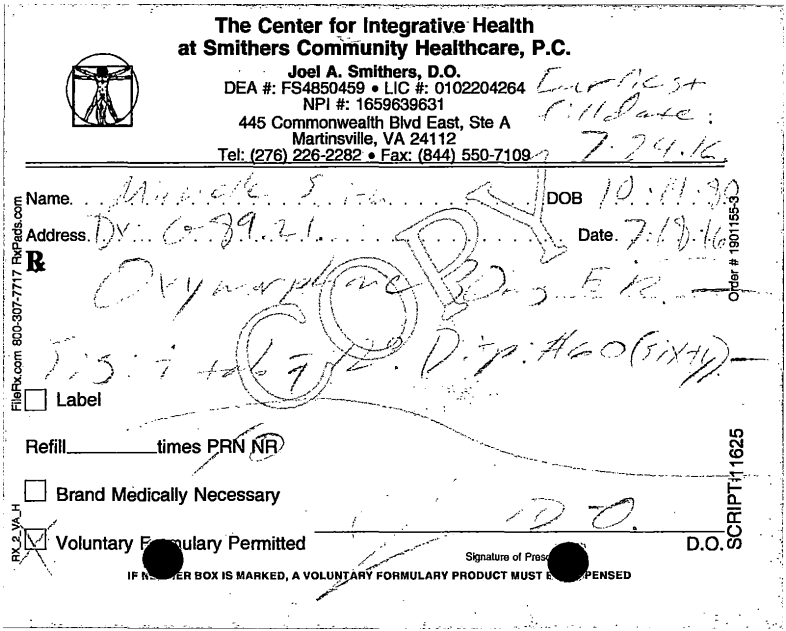
IF NEITHER BOX IS MARKED, A VOLUNTARY FORMULARY PRODUCT MUST BE DISPENSED

FileRx.com 800-307-7717 RxPads.com

RX_2_VA_H

Order # 1901155-3

SCRIPT# 11626



The Center for Integrative Health
at Smithers Community Healthcare, P.C.

Joel A. Smithers, D.O.
DEA #: FS4850459 • LIC #: 0102204264
NPI #: 1659639631
445 Commonwealth Blvd East, Ste A
Martinsville, VA 24112
Tel: (276) 226-2282 • Fax: (844) 550-7109

Earliest Fill Date: 7.24.16

Name. [illegible] DOB 10.11.36

Address. Dr. Co-39.21 Date. 7.19.16

℞ Oxymorphone ER 30 mg Tab

Sig: 1 tab PO q 12 hr. Disp: #60 (SIXTY)

FileRx.com 800-307-7717 RxPads.com

Order # 1901155-3

☐ Label

Refill _____ times PRN NR

☐ Brand Medically Necessary

RX_2_VA_H

☒ Voluntary Formulary Permitted

D.O.

SCRIPT 11625

Signature of Prescriber

IF NEITHER BOX IS MARKED, A VOLUNTARY FORMULARY PRODUCT MUST BE DISPENSED

MS_000046

The Center for Integrative Health
[redacted] Smithers Community Healthcare, P.C.
Joel A. Smithers, D.O.
DEA #: FS4850459 • LIC #: 0102204264
NPI #: 1659639631
445 Commonwealth Blvd East, Ste A
Martinsville, VA 24112
Tel: (276) 226-2282 • Fax: (844) 550-7109

6.21.16.

Name. . . . . DOB 10.14.70

Address. . . . . Date 6.21.16

℞

☐ Label

Refill__________times PRN NR (circled)

☐ Brand Medically Necessary

☒ Voluntary Formulary Permitted

________________________ D.O.
Signature of Prescriber

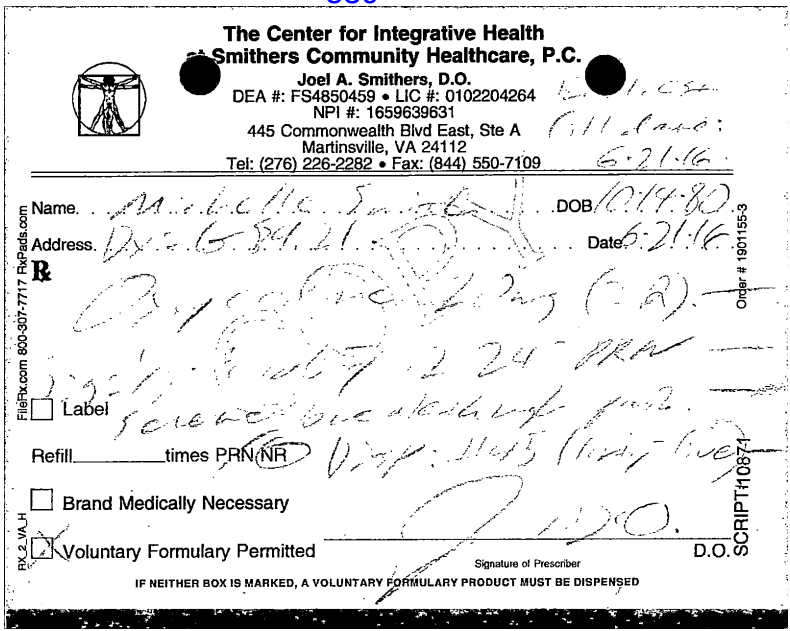
IF NEITHER BOX IS MARKED, A VOLUNTARY FORMULARY PRODUCT MUST BE DISPENSED

FileRx.com 800-307-7717 RxPads.com

Order # 1901155-3

RX_2_VA_H

SCRIPT110870



The Center for Integrative Health
Smithers Community Healthcare, P.C.

Joel A. Smithers, D.O.
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NPI #: 1659639631
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Martinsville, VA 24112
Tel: (276) 226-2282 • Fax: (844) 550-7109

Name. DOB 10.14.80
Address. Date 6.21.16

℞

FileRx.com 800-307-7717 RxPads.com

Order # 1901155-3

☐ Label

Refill_____times PRN NR

☐ Brand Medically Necessary

RX_2_VA_H

☒ Voluntary Formulary Permitted

D.O.

Signature of Prescriber

IF NEITHER BOX IS MARKED, A VOLUNTARY FORMULARY PRODUCT MUST BE DISPENSED

SCRIPT10871

MS_000048

Joel A. Smithers, D.O.
WV LIC: 2913 • VA LIC: 010220464
DEA: FS4850459 • NPI #: 1659639631
445 Commonwealth Blvd East
Martinsville, VA 24112
Phone: (844) 373-7883 • Fax: (844) 550-7109

Name Michelle Smith DOB 10.14.80

Address 6-39-21. Date 1.4.16

℞ MS Contin 15mg

Sig: 1 tab q 12°

COPY

Disp: #60 (sixty)

100

Refill: NR 1 2 3 4 5

D.O.

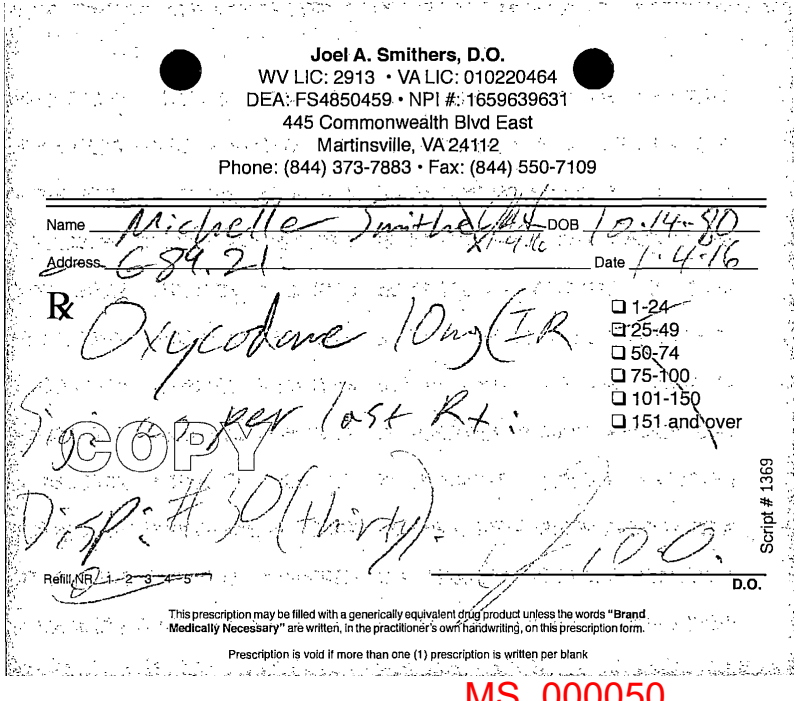
❑ 1-24
❑ 25-49
❑ 50-74
❑ 75-100
❑ 101-150
❑ 151 and over

Script # 1370

This prescription may be filled with a generically equivalent drug product unless the words "**Brand Medically Necessary**" are written, in the practitioner's own handwriting, on this prescription form.

Prescription is void if more than one (1) prescription is written per blank

MS_000049



Joel A. Smithers, D.O.
WV LIC: 2913 • VA LIC: 010220464
DEA: FS4850459 • NPI #: 1659639631
445 Commonwealth Blvd East
Martinsville, VA 24112
Phone: (844) 373-7883 • Fax: (844) 550-7109

Name Michelle Smith DOB 10-14-80
Address 684.21 Date 1-4-16

℞ Oxycodone 10mg (IR
Sig: per last Rx:
Disp: #30 (thirty) 1,00
Refill: NR 1 2 3 4 5

☐ 1-24
☐ 25-49
☐ 50-74
☐ 75-100
☐ 101-150
☐ 151 and over

Script # 1369

D.O.

This prescription may be filled with a generically equivalent drug product unless the words **"Brand Medically Necessary"** are written, in the practitioner's own handwriting, on this prescription form.

Prescription is void if more than one (1) prescription is written per blank

The Center for Integrative Health
at Smithers Community Healthcare, P.C.
Joel A. Smithers, D.O.
DEA #: FS4850459 • LIC #: 0102204264
NPI #: 1659639631
445 Commonwealth Blvd East, Ste A
Martinsville, VA 24112
Tel: (276) 226-2282 • Fax: (844) 550-7109

Name. Michelle Smith... DOB 10-14-8?

Address. Dx: G89.21, G89.4 ... Date. 5-23-16

℞

Oxycodone 30mg PO (IR)
1 tab q 6° PRN severe pain
D-SP: #120 (one hundred twenty)

☐ Label

Refill________times PRN NR

☐ Brand Medically Necessary

☒ Voluntary Formulary Permitted

[signature] D.O.

Signature of Prescriber

IF NEITHER BOX IS MARKED, A VOLUNTARY FORMULARY PRODUCT MUST BE DISPENSED

The Center for Integrative Health
at Smithers Community Healthcare, P.C.
Joel A. Smithers, D.O.
DEA #: FS4850459 • LIC #: 0102204264
NPI #: 1659639631
445 Commonwealth Blvd East, Ste A
Martinsville, VA 24112
Tel: (276) 226-2282 • Fax: (844) 550-7109

Name. *Michelle Smith [illegible]* .DOB *10.11.50*

Address. *Dx: M79.2, M62.838 [illegible]* .. Date. *4.25.16*

℞

Neurontin 400mg, TID, #120.

Zanaflex 4mg, TID for spasms, #60.

Diclofenac 75mg, BID for pain, #60.

Nortriptyline 25mg, qHS, [illegible]

☐ Label

Refill *6* times PRN NR

☐ Brand Medically Necessary

☒ Voluntary Formulary Permitted ______________________ D.O.

Signature of Prescriber

IF NEITHER BOX IS MARKED, A VOLUNTARY FORMULARY PRODUCT MUST BE DISPENSED

**The Center for Integrative Health
at Smithers Community Healthcare, P.C.**

Joel A. Smithers, D.O.
DEA #: FS4850459 • LIC #: 0102204264
NPI #: 1659639631
445 Commonwealth Blvd East, Ste A
Martinsville, VA 24112
Tel: (276) 226-2282 • Fax: (844) 550-7109

Name. Michelle Smith .DOB 10.14.80

Address. Dx: G89.21, G89.4, M54.5. Date. 1.25.16

℞

Oxycodone 30mg (=R).

S: 1/2 - 1 tab q 6-8° PRN severe to moderately severe pain.

☐ Label

Refill______times-PRN NR Disp: #120 (one hundred twenty)

☐ Brand Medically Necessary

☑ Voluntary Formulary Permitted

[signature] D.O.

Signature of Prescriber

IF NEITHER BOX IS MARKED, A VOLUNTARY FORMULARY PRODUCT MUST BE DISPENSED

REMS Screening Inc.
106 Lockheed Drive
Beaver, WV 25813
Ph: 304-894-8721

1st Non-Rx DT (Drug Test) Inconsistency (Unauthorized Licit Substance)

I understand that it is illegal for me to take controlled substances such as **Hydrocodone**, (Name the unauthorized substance(s) detected in the DT) without the prescription of a physician. I understand that my physician may discontinue my current treatment **if I continue to ingest unauthorized controlled substances,** because they are unacceptable "red flags" that constitute a danger to my health and safety. If I continue to "fail" future drug tests, then my physician may begin the titration down or discontinuation of my narcotic medication(s) to ensure my health and safety be maintained.

Client Print Name X **Michelle Smith** Date**06-21-16**

Signature of Client X Michelle Smith Date**06-21-16**

REMS Screener X Date**06-21-16**

Compliance Audit REMS Screening, Inc.

Patient Name: **Michelle Smith** Chart Number: Payer: Primary DOB: **10/14/1980**

Code: 99408/99409 G0396/G0397 H0049/H0050 **ICD9:** Notify:

At age 16 (before pain), did you sleep > 5 hours nightly? Yes
Do you get at least 5 hours sleep in a Bad Night? No
SLEEP ALERT: Nights each week you don't get at least 5 hours sleep uninterrupted by pain? 0

	1
Sunday	1
Monday	1
Tuesday	1
Wednesday	1
Thursday	1
Friday	1
Saturday	1

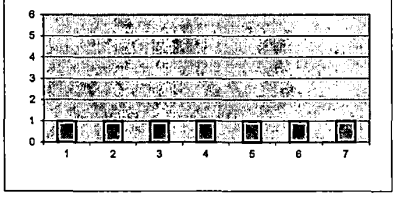
Continuous Sleep Ratings
6 hrs = 0
5 hrs = 1
4 hrs = 2
3 hrs = 3
2 hrs = 4
1 hr or less = 5

Explain 4 Categories of Pain Below

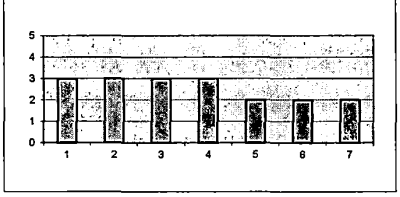
How many "Down Days" per week?	0
How many "Bad Days" per week?	4
How many "Slow Days" per week?	3
How many "Good Days" per week?	0

Sunday	3
Monday	3
Tuesday	3
Wednesday	3
Thursday	2
Friday	2
Saturday	2

Sleep Disability Each Week
0 = > 5 hrs nightly, 5 = < 1 hr solid



"Bad Day" Average Per Week
1 = Good Day, 2 = Slow, 3 = Bad 4 = Down Day, 5 = ER or worse



Status: Worsening (No change, improving, worsening)

By signing this document I affirm that I answered all of the above questions honestly. I also understand that if I lied about any of the questions listed above that I may be charged with an attempt to receive a controlled substance by fraud. I understand that I am legally obligated to tell the truth to the ***Smithers Community Health Care***, and because of this I have answered all of the above questions truthfully.

DAK 11-30-15
Narcotics Auditor

I certify the truthfulness of my answers.
X Michelle Smith
Patient Signature

Compliance Audit REMS Scr[redacted], Inc.

Pre-Screening Audit REMS Screening, Inc.

Patient Name: **Michelle Smith** DOB: **10/14/1980**

96152: Diversion Risk Stratification: Honesty is Vital

Source: Webster LR, Webster RM. Predicting aberrant behaviors in opioid-treated patients: preliminary validation of the Opioid Risk Tool. Pain Med 2005; 6(6):432-442

		Yes/No	Score
1	Is there a history of substance abuse in your family?		
	Alcohol?	No	
	Illegal drugs?	No	
	Other (huffing gas)	No	
2	Do you have a history of substance abuse?		
	Alcohol?	No	
	Illegal drugs?	No	
	Prescription drugs?	No	
3	Is your age between 16 and 45?		
	16-45?	Yes	1
4	Were you a victim of preadolescent (childhood) sexual abuse?		
	Sex Abuse?	No	
5	Do you have a history of any of the following conditions:		
	ADD, OCD, Bipolar,	No	
	Depression?	No	
	Total:		1
	Patient Risk Level:	Low	
	Drug Screen Protocol:	2 - 3 UDT Per Year	

Risk Level		Medically Recommended Urine Drug Screen Protocol
Score	Risk	
0-3	Low	2 - 3 UDT Per Year
4-7	Moderate	4 UDT Per Year
8+	High	4 Plus 1 to 2 Random UDT Per Year

Have you had, or do you have suicudal thoughts or tendencies?	No
Have you ever snorted or injected any substance?	No
Have you taken drugs not Rxed for you?	Yes
Have you ever been tempted to experiment with your meds? (Crush, snort or shoot up)	No
Have you ever received addiction help (AA/NA)?	No
Have you ever been asked to sell or share your medication?	No
Do you have friends who tempt you to abuse/misuse narotics?	No
Have you ever stolen meds or had any stolen from you?	No
Have you ever borrowed any meds from someone?	Yes
Are you currently pregnant?	No
Have you ever received treatment at a methadone or suboxone treatment center?	No
Track Marks? (Examine Patient)	No

Have you ever been charged with, or convicted of any criminal offense? **No**
If "Yes" detail below:

By signing this document I affirm that I answered all of the above questions honestly. I also understand that if I lied about any of the questions listed above that I may be charged with an attempt to receive a controlled substance by fraud. I understand that I am legally obligated to tell the truth to the HOPE Clinic, and because of this I have answered all of the above questions truthfully.

I certify the truthfulness of my answers.

DAK 11-30-15 | X Michelle Smith

Narcotics Auditor | Patient Signature

J.D.O. 11-30-15

Compliance Audit R.E.M.S. Screening Inc.

Patient Name: **Michelle Smith** DOB: **10/14/1980**

At age 16 (before pain), did you sleep > 5 hours nightly? Yes

Do you get at least 5 hours sleep in a Bad Night? No

While Taking Your Current Medications:

SLEEP ALERT: Nights each week you don't get at least 5 hours sleep uninterrupted by pain? 0

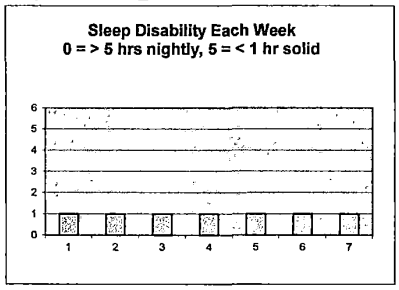
	Sleep Disability
Sunday	1
Monday	1
Tuesday	1
Wednesday	1
Thursday	1
Friday	1
Saturday	1

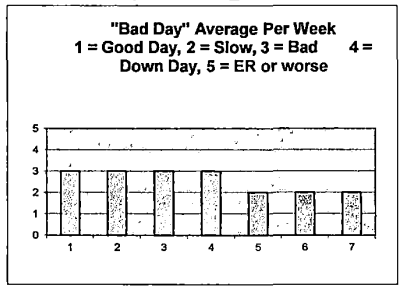
Continuous Sleep Ratings
6 hrs = 0
5 hrs = 1
4 hrs = 2
3 hrs = 3
2 hrs = 4
1 hr or less = 5

Explain 5 Categories of Pain Below

How many "Down Days" per week? 0
How many "Bad Days" per week? 4
How many "Slow Days" per week? 3
How many "Good Days" per week? 0

Sunday	3
Monday	3
Tuesday	3
Wednesday	3
Thursday	2
Friday	2
Saturday	2





Status: No Change (No change, improving, worsening)

Are you pregnant: No - BTL c uterus removed. **Track Marks:** No

BOP Discrepancies: none. **Pill Count Phone #** 606-353-9640

UDT Inconsistencies: Pending **UDT Action Notated:** Pending

Date of last UDT: 5/23/2016 **Address Changed:** No (Update in Kareo)

I certify the truthfulness of my answers.

5-23-16

Narcotics Auditor

X Michelle Smith

Patient Signature

UDT Diversion Risk Stratification: Low (Low = 2 UDT/yr; Moderate = 4 UDT/yr; High = UDT Monthly)

First Failure:

Second Failure:

Third Failure:

D.O.
5-23-16

Compliance Audit R.E.M.S. Screening Inc.

Patient Name: **Michelle Smith** DOB: **10/14/1980**

At age 16 (before pain), did you sleep > 5 hours nightly? Yes
Do you get at least 5 hours sleep in a Bad Night? No

While Taking Your Current Medications:
SLEEP ALERT: Nights each week you don't get at least 5 hours sleep uninterrupted by pain? 0

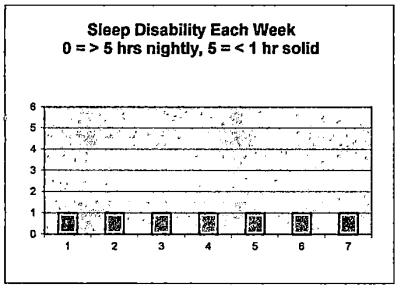
	Sleep Disability
Sunday	1
Monday	1
Tuesday	1
Wednesday	1
Thursday	1
Friday	1
Saturday	1

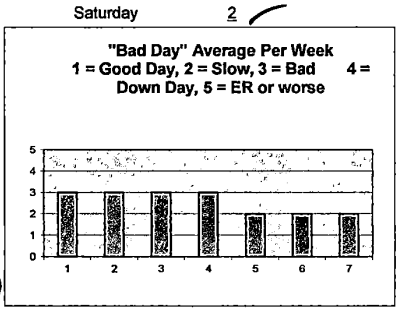
Continuous Sleep Ratings
6 hrs = 0
5 hrs = 1
4 hrs = 2
3 hrs = 3
2 hrs = 4
1 hr or less = 5

Explain 5 Categories of Pain Below

How many "Down Days" per week?	0
How many "Bad Days" per week?	4
How many "Slow Days" per week?	3
How many "Good Days" per week?	0

Sunday	3
Monday	3
Tuesday	3
Wednesday	3
Thursday	2
Friday	2
Saturday	2





Status: Improving (No change, improving, worsening)

Are you pregnant: No. PAH
Track Marks: No
BOP Discrepancies: none
Pill Count Phone # 606-353-9640
UDT Inconsistencies: Yes
UDT Action Notated: Yes
Date of last UDT: 5/23/2016
Address Changed: No (Update in Kareo)
I certify the truthfulness of my answers.

7-18-16
Narcotics Auditor

X Michelle Smith
Patient Signature

UDT Diversion Risk Stratification: Moderate (Low = 2 UDT/yr; Moderate = 4 UDT/yr; High = UDT Monthly)

First Failure:

Second Failure:

Third Failure:

I.D.U.

Compliance Audit R.E.M.S. Screening Inc.

Patient Name: **Michelle Smith** DOB: **10/14/1980**

At age 16 (before pain), did you sleep > 5 hours nightly? Yes

Do you get at least 5 hours sleep in a Bad Night? No

While Taking Your Current Medications:

SLEEP ALERT: Nights each week you don't get at least 5 hours sleep uninterrupted by pain? 0

	Sleep Disability
Sunday	1
Monday	1
Tuesday	1
Wednesday	1
Thursday	1
Friday	1
Saturday	1

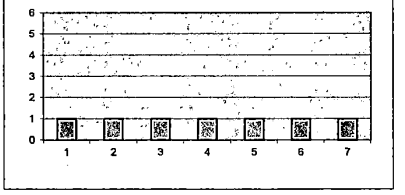
Continuous Sleep Ratings
6 hrs = 0
5 hrs = 1
4 hrs = 2
3 hrs = 3
2 hrs = 4
1 hr or less = 5

Explain 5 Categories of Pain Below

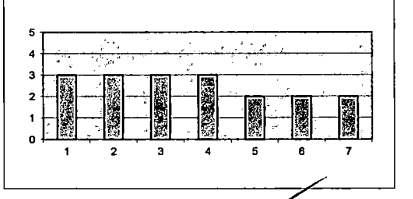
How many "Down Days" per week?	0
How many "Bad Days" per week?	4
How many "Slow Days" per week?	3
How many "Good Days" per week?	0

Sunday	3
Monday	3
Tuesday	3
Wednesday	3
Thursday	2
Friday	2
Saturday	2

Sleep Disability Each Week
0 = > 5 hrs nightly, 5 = < 1 hr solid



"Bad Day" Average Per Week
1 = Good Day, 2 = Slow, 3 = Bad 4 = Down Day, 5 = ER or worse



Status: Worsening (No change, improving, worsening)

Are you pregnant: No

Track Marks: No

BOP Discrepancies: none

Pill Count Phone # 606-353-9640

UDT Inconsistencies: Yes

UDT Action Notated: Yes

Date of last UDT: 5/23/2016

Address Changed: No (Update in Kareo)

I certify the truthfulness of my answers.

D. Collins 6-21-16 | X Michelle Smith

Narcotics Auditor | Patient Signature

UDT Diversion Risk Stratification: Moderate (Low = 2 UDT/yr; Moderate = 4 UDT/yr; High = UDT Monthly)

First Failure:

Second Failure:

Third Failure:

10.0

6.21.16

Confirmatrix LABORATORY
Accurate • Rapid • Consistent

Laboratory Report

Laboratory Director Stanley Y. Wu, Ph.D., NRCC-TC
CLIA Number 11D2047828
1770 Cedars Rd., Suite 200
Lawrenceville, GA 30045
(678) 407-9818 - Fax (678) 407-9819

Client Information

Smithers Community Health Care
445 Commonwealth Blvd
Martinsville, VA 24112
Requesting Physician / Practitioner:
Smithers, Joel

Patient Information

Patient Name: Smith, Michelle
Patient ID: 16-144-032
Date of Birth: 10/14/1980
Male/Female: Female

Sample Information

Lab Sample ID: mith1244-16144
Accession #: 1605260275
Specimen Type: Urine
Collected: 05/23/2016
Received: 05/26/2016
Reported: 05/28/2016

Medications Prescribed

Diclofenac, Gabapentin, Nortriptyline, Oxycodone, Zanaflex

Comments

- Toxicology performance specifications and validations were developed in accordance to industry standards by Confirmatrix Laboratory (CLI). They are considered a Laboratory Developed test (LDT). LDT's are not approved by the FDA. CLI is a high complexity lab accredited by COLA in accordance with CLIA '88 requirements.

Test	Result	Quantitation	Outcome	Cutoff
Qualitative Drugs of Abuse with Specimen Validity and Quantitative Reflex				
Amphetamines, Qualitative	Negative			<500 ng/mL
Barbiturates, Qualitative	Negative			<200 ng/mL
Benzodiazepines, Qualitative	Negative			<200 ng/mL
Benzoylecgonine (Cocaine Metabolite), Qualitative	Negative			<150 ng/mL
Buprenorphine,Qualitative	Negative			<5 ng/mL
Ecstasy (MDMA), Qualitative	Negative			<500 ng/mL
ETG, Qualitative	Negative			<500 ng/mL
Meperidine, Qualitative	Negative			<200 ng/mL
Methadone,Qualitative	Negative			<300 ng/mL
Opiates, Qualitative	**Positive**			**<300 ng/mL**
Opiate screening assay is presumptive positive, unconfirmed. This may be due to the presence of one or more opiate drugs, including their metabolites. A positive assay result for opiates may also represent cross-reaction with other drugs. Further testing is required for confirmation and drug identification.				
Oxycodone,Qualitative	**Positive**			**<100 ng/mL**
Oxycodone screening assay is presumptive positive, unconfirmed. This may be due to the presence of oxycodone, oxymorphone, and/or their metabolites. A positive assay result for oxycodone may also represent cross-reaction with other drugs. Further testing is required for confirmation and drug identification.				
THC, Qualitative	Negative			<20 ng/mL
Urine Creatinine		181		20-300 mg/dL
Urine pH		6.6		4.6-8.0
Urine Specific Gravity		1.027		1.002-1.030
Urine Oxidants	Negative			<50 ug/mL

Test	Result	Quantitation	Outcome	Cutoff
Antidepressants and Psychotropics by LC/MS/MS				
Nortriptyline	**Negative**		**Inconsistent**	**50 ng/mL**
Anticonvulsants and Other Neurologic Meds by LC/MS/MS				
Gabapentin	**Negative**		**Inconsistent**	**1000 ng/mL**
Illicit Drugs by LC/MS/MS				
6-MAM	Negative			25 ng/mL
Opiates/Opioids by LC/MS/MS				
Codeine	Negative			50 ng/mL
Morphine	Negative			50 ng/mL
Normorphine	Negative			200 ng/mL
Hydromorphone	Negative			50 ng/mL

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Sample Information

Lab Sample ID: mith1244-16144
Accession #: 1605260275
Specimen Type: Urine
Collected: 05/23/2016
Received: 05/26/2016
Reported: 05/28/2016

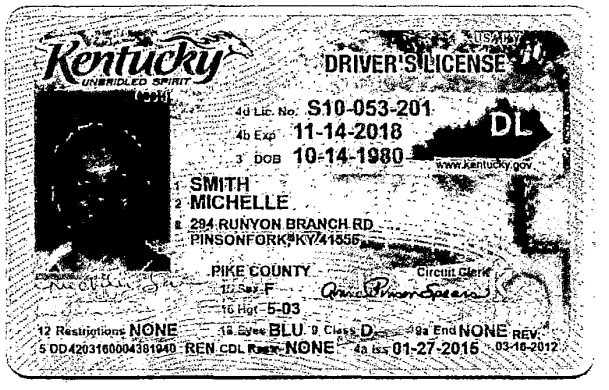
Test	Result	Quantitation	Outcome	Cutoff
Hydrocodone	**Positive**	1235	**Inconsistent**	**50 ng/mL**
Detection window 2-4 days. Hydrocodone (Zohydro, ingredient in Norco, Lortab, Vicodin) is a semi-synthetic opioid narcotic, widely used as an analgesic (often in combination with acetaminophen) and an antitussive. Norhydrocodone, hydromorphone, and dihydrocodeine are metabolites of hydrocodone. Hydrocodone may be seen as a minor metabolite of codeine.				
Dihydrocodeine	**Positive**	73	**Inconsistent**	**50 ng/mL**
Detection window 2-4 days. Dihydrocodeine is most commonly seen in the urine as a minor metabolite of hydrocodone. It is sometimes prescribed as an antitussive (Synalgos-DC).				
Norhydrocodone	**Positive**	1746	**Inconsistent**	**50 ng/mL**
Detection window 2-4 days. Norhydrocodone is a primary metabolite of hydrocodone.				
Oxycodone	**Positive**	>7500	**Consistent**	**50 ng/mL**
Detection window 2-4 days. Oxycodone (Oxycontin, Roxicodone, ingredient in Endocet, Percocet, Tylox) is a semi-synthetic opioid analgesic used (often in combination with acetaminophen or aspirin) to treat moderate to severe pain. Oxycodone metabolizes into noroxycodone and oxymorphone.				
Noroxycodone	**Positive**	>5000	**Consistent**	**50 ng/mL**
Detection window 2-3 days. Noroxycodone is a primary metabolite of oxycodone. Its presence indicates recent use of oxycodone.				
Oxymorphone	**Positive**	>2500	**Consistent**	**50 ng/mL**
Detection window 2-4 days. Oxymorphone (Opana) is a potent semi-synthetic opioid analgesic used to treat moderate to severe pain. Oxymorphone is also a metabolite of oxycodone. Its presence indicates recent use of oxymorphone, oxycodone, or both.				
Buprenorphine	Negative			5 ng/mL
Norbuprenorphine	Negative			10 ng/mL
Naloxone	Negative			10 ng/mL
Fentanyl	Negative			2 ng/mL
Norfentanyl	Negative			8 ng/mL
Meperidine	Negative			50 ng/mL
Normeperidine	Negative			100 ng/mL
Methadone	Negative			100 ng/mL
EDDP	Negative			100 ng/mL
Naltrexone	Negative			10 ng/mL
Propoxyphene	Negative			100 ng/mL
Norpropoxyphene	Negative			100 ng/mL
Sufentanil	Negative			5 ng/mL
Tapentadol	Negative			50 ng/mL
Nortapentadol	Negative			50 ng/mL
Tramadol	Negative			100 ng/mL
O-Desmethyltramadol	Negative			100 ng/mL

• Pt reports Hydro - d/t cough syrup from illness.
• Pt indicates she took an OpER (2) over a couple days before visit d/t TH pain & 5 Neurontin & Tramadol.

J ID D. 6.21.16

SS# 407-19-2294

Phone# 606-353-9640 home



Smithers Community Healthare, PC Patient Contact Form

Patient Name: (First) Michelle (Last) Smith (MI)
Patient Address: 294 Runyon Branch Rd
City: Pinsonfork State: KY Zip: 41555
Home Phone: 606-353-9640 Cell/Pager:
Birthdate: 10-4-1980 Age: 35 Sex: M (F)
Country of Birth: USA Country of Parents' Birth: USA

Employment and Insurance Information:
Patient Employer: Occupation:
Employer Address:
City: State: Zip
Work phone No: Ext.
Social Security: 407-19-2294 Drivers License:
Primary Insurance Carrier:
Policy #: Group #:
Primary Insurance Address:
City: State: Zip
Primary Insurance Phone #:

In Case of Emergency:
Name: Relationship: Phone:
Patient's Spouse: Phone:
Family Physician: Phone:
Referred by:

FDLMP (first day of last menstrual period):
Are you pregnant or trying to become pregnant?:

Smithers Community Healthcare, PC Consent for Treatment

I certify that the above information is accurate, complete and true.

I authorize Smithers Community Healthcare, PC and any associates, assistants, and other health care providers it may deem necessary, to treat my condition. I understand that no warranty or guarantee has been made of a specific result or cure. I agree to actively participate in my care to maximize its effectiveness.

I give my consent for Smithers Community Healthcare, PC to retrieve and review my medication history. I understand that this will become part of my medical record.

I acknowledge that I have had the opportunity to review Smithers Community Healthcare, PC Notice of Privacy Practices, which is displayed for public inspection at its facility and on its website. This Notice describes how my protected health information may be used and disclosed, and how I may access my health records.

I authorize the Smithers Community Healthcare, PC to release my Protected Health Information (medical records) in accordance with its Notice of Privacy Practices. This includes, but is not limited to, release to my referring physician, primary care physician, and any physician(s) I may be referred to. I also authorize Smithers Community Healthcare, PC to release any information required in obtaining procedure authorization or the processing of any insurance claims.

I understand that Smithers Community Healthcare, PC will not release my Protected Health Information to any other party (including family) without my completing a written "Patient Authorization for Use and Disclosure of Protected Health Information" form, available at its facility and by fax.

Signed: Michelle Smith Date: 11-30-15

Agreement for Opioid Maintenance Therapy for Non-cancer/Cancer Chronic Pain

The purpose of this agreement is to give you information about the medications you will be taking for pain management and to assure that you and your physician comply with all state and federal regulations concerning the prescribing of controlled substances. The physician's goal is for you to have the best quality of life possible given the reality of your clinical condition. A trial of opioid therapy can be considered for moderate to severe pain with the intent of reducing pain and increasing function. If you file for disability after becoming our patient, or your attorney seeks to submit our treatment records as evidence for your disability case, your treatment will be considered a failure, and our opiate treatment of your pain will be discontinued. The success of treatment depends on mutual trust and honesty in the Physician/Patient Relationship and full agreement and understanding of the risks and benefits of using opiates to treat pain.

1. You must use only one physician to prescribe and monitor all opiate medications and adjunctive analgesics.

2. You must use only one pharmacy to obtain all opiate prescriptions and adjunctive analgesics prescribed by your physician. Pharmacy:_____ Address:_____

3. You should inform your physician of all medications you are taking, including herbal remedies, since opiate medications can interact with over-the-counter medications and other prescribed medications, especially cough syrup that contains alcohol, codeine, or hydrocodone.

4. You will be seen on a regular basis and given prescriptions for enough medication to last from appointment to appointment, plus usually two to three days extra. This extra medication is not to be used without the explicit permission of the prescribing physician unless an emergency requires your appointment to be deferred one or two days. (You will be charged a new patient fee if you fail to reschedule your appointment at least 48 hours in advance)

5. Prescriptions for pain medicine or any other prescriptions will be done during an office visit or during regular office hours. No refills of any medications will be done during the evening or on weekends. You must NOT tell anyone you are taking pain medicine and you must NOT tell anyone you are receiving pain medicine prescriptions from our office.

6. You must bring back all opiate medications and adjunctive medications prescribed by your physician in the original bottles when you are called in for a Pill Count.

7. You are responsible for keeping your pain medication in a safe and secure place, such as a locked cabinet or safe. You are expected to protect your medications from loss or theft. Stolen medications should be reported to the police and to your physician immediately. If your medications are lost, misplaced, or stolen, your physician will NOT replace the medication and may taper or discontinue the medications.

8. You may not give or sell your medications to any other person under any circumstances. If you do, you may endanger that person's health, and it is also against the law.

9. Any evidence of drug hoarding, including undestroyed medications prescribed over 30 days ago, acquisition of any opiate medication or adjunctive analgesia from other physicians (which includes emergency rooms), uncontrolled dose escalation or reduction, loss of prescriptions, or failure to follow the agreement may result in termination of the Doctor/patient relationship.

10. You will communicate fully to your physician to the best of your ability at the initial and all follow-up visits your pain level and functional activity level along with any side effects of the medications. This information allows your physician to adjust your treatment plan accordingly.

11. You agree to obtain all your non-opiate medications from a Family Physician or an appropriate medical provider.

12. You may not use any illicit substances, such as marijuana, cocaine, heroin, methamphetamines, etc. during treatment with Dr. Joel A. Smithers, D.O. This may result in a change to your treatment plan, including safe discontinuation of your opiate medications when applicable, or complete termination of the Doctor/Patient relationship.

13. You agree and understand that your physician reserves the right to perform random or unannounced pill counts and urine drug testing. If requested, you agree to cooperate. You must ensure we always have your most current phone number and address. If you decide not to follow our instructions, you understand that your Doctor may change your treatment plan, including safe discontinuation of your opiate medications when applicable, or complete termination of the Doctor/Patient relationship. The presence of a non-prescribed drug(s) or illicit drug(s) in the urine can be grounds for termination of the Doctor/Patient relationship.

14. There are side effects with opiate therapy, which may include, but not exclusively, skin rash, constipation, sexual dysfunction, sleeping abnormalities, sweating, edema, sedation, or the possibility of impaired cognitive (mental status) and/or motor ability. Overuse of opiates can cause decreased respiration (breathing) or death. The use of alcohol and opiate medications is contraindicated and prohibited, and Smithers Community Healthcare, P.C. regularly tests for alcohol along with other prohibited substances.

15. Physical dependence and/or tolerance can occur with the use of opiate medications.

    Physical dependence means that if the opiate medication is abruptly stopped or not taken as directed, a withdrawal symptom can occur. This is a normal physiological response. The withdrawal syndrome could include, but not exclusively, sweating, nervousness, abdominal cramps, diarrhea, goose bumps, and alterations in one's mood. It should be noted that physical dependence does not equal addiction. One can be dependent on insulin to treat diabetes or dependent on prednisone (steroids) to treat asthma, but one is not addicted to the insulin or prednisone.

    Addiction is a primary, chronic neurobiological disease with genetic, psychosocial and environmental factors influencing its development and manifestation. It is characterized by behavior that includes one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and cravings. This means the drug decreases one's quality of life.

16. If you have a history of alcohol or drug misuse/addiction, you must notify the physician of such history since the treatment with opiates for pain may increase the possibility of relapse. A history of addiction does not, in most instances, disqualify one for opiate treatment of pain, but starting or continuing a program for recovery is a must.

17. You agree to NOT donate blood or plasma without gaining permission from your physician.

18. You agree to allow your physician to contact any healthcare professional, family member, pharmacy, legal authority, or regulatory agency to obtain or provide information about your care or actions if the physician feels it is necessary.

19. You agree to a family conference or a conference with a close friend or significant other, if the physician feels it is necessary.

20. You may be dismissed from opiate therapy if you do NOT keep the requirements of this pain care agreement.

The above agreement has been explained to me by Dr. Smithers and I agree to its terms so that the physician can provide quality pain management using opiate therapy to decrease my pain and increase my function.

Patient's Signature Michelle Sm Date 11-30-15

Witness's Signature J.D.C. Date 11-30-15

Smithers Community Healthare, PC Patient Contact Form

Patient Name: (First) Michelle (Last) Smith (MI) _____
Patient Address: 294 Runyon Branch
City: Pinsonfork State: Ky Zip: 41555
Home Phone: (606) 353-9690 Cell/Pager: _____
Birthdate: 10-14-80 Age: 35 Sex: M (F)
Country of Birth: USA Country of Parents' Birth: USA

Employment and Insurance Information:
Patient Employer: _____ Occupation: _____
Employer Address: _____
City: _____ State: _____ Zip _____
Work phone No: _____ Ext. _____
Social Security: 407-19-2294 Drivers License: _____
Primary Insurance Carrier: _____
Policy #: _____ Group #: _____
Primary Insurance Address: _____
City: _____ State: _____ Zip _____
Primary Insurance Phone #: _____

In Case of Emergency:
Name: _____ Relationship: _____ Phone: _____
Patient's Spouse: _____ Phone: _____
Family Physician: _____ Phone: _____
Referred by: _____

FDLMP (first day of last menstrual period): _____
Are you pregnant or trying to become pregnant?: _____

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1. You must use only one physician to prescribe and monitor all opiate medications and adjunctive analgesics.

2. You must use only one pharmacy to obtain all opiate prescriptions and adjunctive analgesics prescribed by your physician. Pharmacy: Old Virginia Address: Virginia

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Patient's Signature Michelle Lee Date 6-21-16

Witness's Signature J.D. Date 6-21-16

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I understand that Smithers Community Healthcare, PC will not release my Protected Health Information to any other party (including family) without my completing a written "Patient Authorization for Use and Disclosure of Protected Health Information" form, available at its facility and by fax.

Signed: Michelle Lee Date: 6-21-14